SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

My 2019

SHBP RETIREE DECISION GUIDE

Retiree Option Change Period (ROCP) | October 15 - November 2, 2018

WWW.MYSHBPGA.ADP.COM

STATE HEALTH BENEFIT PLAN RESOURCES/CONTACT INFORMATION

MEDICAL CLAIMS ADMINISTRATOR	MEMBER SERVICES	WEBSITE
Anthem Blue Cross and Blue Shield (Anthem)		
Medicare Advantage Pre-Enrollment (First Impressions)	855-322-7060	www.AnthemRetiree.com/SHBP
Medicare Advantage Post-Enrollment (Member Services)	855-322-7062	
Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET	855-641-4862 (TTY 711)	
Fraud Hotline	800-831-8998	
UnitedHealthcare		
Medicare Advantage Customer Service	877-246-4190	www.uhcretiree.com/shbp
Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET (call 24 hours a day/7 days per week for Nurseline support)	888-364-6352 (TTY 711)	www.welcometouhc.com/shbp
MA Fraud Hotline	877-246-4190	
Fraud Hotline	866-242-7727	
Kaiser Permanente (KP)		
Member Services: Monday thru Friday, 7:00 a.m. to 7:00 p.m. ET (call 24 hours a day/7 days per week for Appointment Scheduling, Prescriptions and Nurse Advice)	855-512-5997 (TTY 711)	my.kp.org/shbp
Wellness Program Customer Service Monday thru Friday, (except Holidays) 11:00 a.m. to 8:00 p.m. ET	866-300-9867	
Kaiser Permanente Rollover Account (KPRA) Customer Service Monday thru Friday, (except Holidays) 11:00 a.m. to 8:00 p.m. ET	877-761-3399	www.kp.org/healthpayment
Fraud Hotline	855-512-5997	
Wellness Program Administrator	**Member Services**	**Website**
Sharecare Member Services: Monday thru Friday, 8:00 a.m. to 8:00 p.m. ET	888-616-6411 (TTY 711)	www.BeWellSHBP.com
Corporate Compliance	844-401-0005 (TTY 711)	
Pharmacy Administrator	**Member Services**	**Website**
CVS Caremark Member Services: 24 hours a day/7 days per week	844-345-3241	http://info.caremark.com/shbp
TTY Line	800-231-4403	
Fraud Hotline	877-CVS-2040	
SHBP	**Member Services**	**Website**
SHBP Member Services ROCP: Monday thru Friday, 8:30 a.m. to 7:30 p.m. ET, Saturday, 8:00 a.m. to 5:00 p.m. ET Regular Business Hours: Monday thru Friday, 8:30 a.m. to 5:00 p.m. ET, Saturday, 8:00 a.m. to 5:00 p.m. ET	800-610-1863	www.mySHBPga.adp.com
Additional Information	**Member Services**	**Website**
TRICARE Supplement	866-637-9911	www.selmantricareresource.com/ga_shbp
Social Security Administration	800-772-1213	www.ssa.gov
Centers for Medicare & Medicaid Services (CMS)	**Help Line**	**Website**
24 hours a day/7 days per week	800-633-4227	www.medicare.gov
	TTY 877-486-2048	

The material in this Decision Guide is for informational purposes only and is not a contract. It is intended only to highlight principal benefits of the SHBP Plan Options. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan Documents, the Plan Documents govern. It is the responsibility of each member, active and retired, to read all Plan materials provided to fully understand the provisions of the option chosen. Availability of SHBP Options may change based on federal or state law changes or as approved by the Board of Community Health. Premiums for SHBP options are established by the Board of Community Health and may be changed at any time by Board Resolution, subject to advance notice.

2018 Retiree Option Change Period (ROCP) for Plan Year 2019

Welcome to the State Health Benefit Plan's (SHBP) Retiree Option Change Period (ROCP) for the 2019 Plan Year. ROCP gives you the opportunity to review the Plan Options and make changes to your coverage based on your needs. Please read this document carefully to ensure you are choosing the option that best meets your, and your covered dependents health care needs.

CONTENTS

COMMON HEALTH CARE ACRONYMS

ANTHEM	Anthem Blue Cross and Blue Shield
CMS	Centers for Medicare & Medicaid Services
DCH	Department of Community Health
FSA	Flexible Spending Account
HDHP	High Deductible Health Plan
HIA	Health Incentive Account
HMO	Health Maintenance Organization
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
KP	Kaiser Permanente
KPRA	Kaiser Permanente Rollover Account
MAPD	Medicare Advantage with Prescription Drugs
MIA	MyIncentive Account
OE	Open Enrollment
PCP	Primary Care Physician
PPO	Preferred Provider Organization
QE	Qualifying Event
RRA	Retiree Reimbursement Account
SHBP	State Health Benefit Plan
SPC	Specialist
SPD	Summary Plan Description

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Nathan Deal, Governor **Frank W. Berry, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

Dear State Health Benefit Plan (SHBP) Retiree:

It is my pleasure as Commissioner of the Department of Community Health (DCH) to welcome you to the 2018 Retiree Option Change Period (ROCP) for Plan Year 2019. Retirees can make their elections online in the SHBP Enrollment Portal at www.mySHBPga.adp.com, from Monday, October 15, 12:00 a.m. ET through Friday, November 2, 2018, 11:59 p.m. ET. Retirees may also enroll by contacting SHBP Member Services at **800-610-1863** during its extended hours for ROCP, Monday – Friday from 8:30 a.m. ET to 7:30 p.m. ET and Saturday, 8:00 a.m. ET to 5:00 p.m. ET.

In 2019, SHBP will continue to provide members with the same high quality plan designs that we offered in Plan Year 2018. Please verify the rates prior to making your selection. The plan designs for 2019 include:

For our Age 65 and older Medicare eligible Retirees: the Medicare Advantage Standard and Premium Plan Options offered by Anthem and UnitedHealthcare, and

For our Pre-65 Retirees: the Gold, Silver, and Bronze Health Reimbursement Arrangement (HRA) Plan Options offered by Anthem, the High Deductible Health Plan (HDHP) Plan Option offered by UnitedHealthcare, the statewide Health Maintenance Organization (HMO) Plan Options offered by Anthem and UnitedHealthcare, and the regional HMO Plan Option offered by Kaiser Permanente.

SHBP is also offering additional benefits for our Retirees enrolled in Commercial (non-Medicare Advantage) Plan Options, which include:

A new wellness incentive structure offered by Sharecare that will allow Members the option to redeem their incentive points for either 1) a $150 Visa Gift Card (when redeeming all 480 well-being incentive points earned in 2019) to use anywhere Visa is accepted **OR** 2) 480 well-being incentive credits (to apply toward eligible medical or pharmacy expenses) **OR** 3) A $225 Walmart Gift Card (when redeeming all 480 well-being incentive points in 2019) to be used in Walmart stores for pharmacy prescriptions and vision items (restrictions apply), and

Mental health benefits in parity with medical benefits, which removes the age limit for ABA therapy, and allows SHBP to cover both Residential Treatment Centers (RTC) and Methadone clinics.

Choosing the right health coverage for you and your covered family members can be overwhelming. I encourage you to use the Decision Support Tools offered in the SHBP Enrollment Portal, to view the Plan Documents on our website at https://shbp.georgia.gov, and to reach out to SHBP Member Services at **800-610-1863** and directly to Anthem, Kaiser Permanente, and UnitedHealthcare as you consider the various Plan Options.

Thank you for being a valued Member of your SHBP and supporting DCH's mission to provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

Sincerely,

Frank W. Berry

WELCOME

TO THE RETIREE OPTION CHANGE PERIOD

Welcome to the Georgia Department of Community Health (DCH), State Health Benefit Plan's (SHBP) annual 2018 Retiree Option Change Period (ROCP) for the 2019 Plan Year.

From Monday, October 15, 12:00 a.m. ET through Friday, November 2, 2018, 11:59 p.m. ET, over 100,000 Retirees will have the opportunity to continue their current plan option or enroll in another plan option. Those options will include the same high-quality plan designs that we offered in Plan Year 2018.

On behalf of our Governor, Nathan Deal, Commissioner Frank W. Berry, the Board of Community Health and the entire SHBP family, I encourage you to explore and carefully choose the plan options that meet the needs of you and your family in 2019.

This Retiree Decision Guide is customized for you, our Retirees. It outlines plan options and specific benefit changes that will become effective January 1, 2019 and continue through December 31, 2019. Additionally, you may view the Plan Documents and other helpful information regarding the SHBP on our website at www.shbp.georgia.gov.

SHBP thanks you for the opportunity to serve you and continue our commitment to offer *affordable, quality healthcare* for all SHBP members.

Sincerely,

Jeff Rickman
Division Chief, SHBP

2019 Medical Claims Administrators, Plan Options and Enhanced Benefits

Medical Claims Administrators

Anthem Blue Cross and Blue Shield (Anthem), Kaiser Permanente (KP), and UnitedHealthcare will continue to offer State Health Benefit Plan (SHBP) members the Plan Options listed below for 2019.

Plan Option Offerings

Health Maintenance Organization (HMO)

- Anthem
- KP (Metro Atlanta Service Area In-Network only plan)
- UnitedHealthcare

High Deductible Health Plan (HDHP) with an option to open a HSA

- UnitedHealthcare

Health Reimbursement Arrangement (HRA) without co-pays

- Anthem: Gold, Silver and Bronze

Medicare Advantage with Prescription Drugs (MAPD) Preferred Provider Organization (PPO) Standard and Premium

- Anthem
- UnitedHealthcare

WELLNESS INCENTIVES

AT-A-GLANCE

2019 WELLNESS INCENTIVES AT-A-GLANCE See 2019 Wellness section for details					
Plan Option	**Anthem HMO MyIncentive Account (MIA)**	**Anthem Health Reimbursement Arrangement (HRA)**	**Kaiser Permanente (KP) Regional HMO**	**UnitedHealthcare HMO Health Incentive Account (HIA)**	**UnitedHealthcare HDHP Health Incentive Account (HIA)**
Who's Eligible	Up to	Up to		Up to	Up to
Member	480	480	$500*	480	480
Spouse	480	480	$500*	480	480
Bonus credits for member and spouse**	n/a	n/a	n/a	480**	480**
Potential Total	960	960	$1,000*	1,440	1,440

Anthem: *members enrolled in an Anthem HRA Plan Option will receive SHBP-funded base credits at the beginning of the Plan Year. The amount funded will be based on your elected coverage tier. If you enroll in a HRA during the Plan Year, these credits will be prorated based on the elected coverage tier and the months remaining in the current Plan Year.*

****KP:*** *members enrolled in the KP Regional HMO Plan Option and their covered spouses will each receive a $500 Mastercard reward card after they each satisfy KP's Wellness Program requirements.*

*****UnitedHealthcare:*** *New for 2019! Spouses enrolled in an UnitedHealthcare Plan Option can now earn a 240 well-being incentive credit match. This means Members and their covered spouses enrolled in an UnitedHealthcare Plan Option can each earn a 240 well-being incentive credit match with a maximum combined up to 480 well-being incentive credits matched by UnitedHealthcare for completing wellness requirements under the plan. After credits are added to your HIA, any remaining credits will rollover each plan year.*

What's New in 2019

New Wellness Incentive Structure for Anthem Blue Cross and Blue Shield and UnitedHealthcare Commercial (Non-Medicare Advantage) Plan Options

Members enrolled in Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial Plan Options can earn 480 well-being incentive points and choose to redeem them in the Sharecare Redemption Center for either:

1. A $150 Visa Reward Card (when redeeming all 480 well-being incentive points earned in 2019) to use anywhere Visa is accepted; **OR**
2. 480 well-being incentive credits to apply toward eligible medical or pharmacy expenses (well-being incentive points earned in 2019 can be redeemed for well-being incentive credits in increments of 120); **OR**
3. A $225 Walmart Gift Card (when redeeming all 480 well-being incentive points earned in 2019) to be used in Walmart stores for pharmacy prescriptions and vision items (restrictions apply)

See 2019 Wellness section for details.

Applied Behavior Analysis (ABA) for Autism

SHBP provides limited coverage for medically necessary ABA for the treatment of Autism Spectrum Disorder (ASD) to a maximum benefit of $35,000 per year per approved member. Applicable co-pays, deductibles and/or co-insurance may apply to all covered services. For more information regarding ABA coverage, please call your Medical Claims Administrator's member service number.

Methadone Clinics and Residential Treatment

New in 2019, Mental Health Benefits will be expanded to include coverage for methadone clinics and residential treatment centers. Prior approval thorough your elected Medical Claims Administrator (Anthem, Kaiser Permanente, or UnitedHealthcare) will be required.

Important Plan Reminders

New Identification Cards

All Anthem, UnitedHealthcare and *new* Kaiser Permanente Members will receive new identification cards before January 1st. Due to mailing restrictions, Members may receive cards at different times.

Social Security Number (SSN) or other Taxpayer Identification Number (TIN)

All members must provide SHBP with their Taxpayer Identification Number (TIN) for themselves and their enrolled dependents upon enrolling in SHBP coverage. The most common type of TIN is a Social Security Number (SSN), but for individuals who are not eligible for a SSN, members may submit an Individual Taxpayer Identification Number (ITIN) or Adoption Taxpayer Identification Number (ATIN). Failure to submit a TIN will result in a loss of coverage and no refund will be issued.

The requirement to provide a SSN or other TIN is a separate process from Dependent Verification. Dependents whose coverage is terminated due to providing an invalid SSN or no SSN are not eligible for coverage even if they passed the Dependent Verification process as they have failed to provide a valid SSN to SHBP.

Members should provide their dependent's SSN by entering it directly into the SHBP Enrollment Portal at https://myshbpga.adp.com/shbp/ or by calling SHBP Member Services at 800-610-1863.

Dependent Verification

Certain Qualifying Events (QE) are opportunities to add eligible dependents to your coverage. SHBP requires documentation confirming eligibility of newly added dependents covered under the Plan. Please see the Eligibility & Enrollment Provisions at www.shbp.georgia.gov for the acceptable documentation. If you elect to cover dependents, generally, they will be placed in a pending status until: 1) the required documentation is submitted within 45 days of the QE proving they are eligible for coverage, or 2) until the deadline to provide the documentation has passed, whichever occurs first.

Important Plan Reminders (continued)

There's Still Time to Earn 2018 Well-Being Incentive Credits

Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial (Non-Medicare Advantage) Plan Options: Members and their covered spouses currently enrolled in Anthem and UnitedHealthcare Commercial Plan Options who have not completed the required health actions or have not taken any actions have until November 30, 2018 to:

- Complete all required actions, and
- Submit the 2018 Physician Screening Form to earn the 2018 well-being incentive credits.

If you have questions or need help getting started, visit www.BeWellSHBP.com or contact Sharecare at 888-616-6411.

Kaiser Permanente: Members and their covered spouses currently enrolled in the KP Regional HMO Plan Option have until November 30, 2018 to complete all four wellness activities to receive a $500 Mastercard reward card. Visit KP's website at www.my.kp.org/shbp or contact KP's wellness program customer service at 866-300-9867 for details and if you have questions or need help getting started.

2018 Rollover Credits for Commercial (Non-MA) Plan Options: Regardless of what Plan Option you select, all unused well-being incentive credits earned in 2018 will automatically roll over to your 2019 Plan Option you choose during the Retiree Option Change Period (ROCP). SHBP will deposit your unused credits in the incentive account associated with your 2019 plan selection in April 2019. If you remain with the same Medical Claims Administrator and in the same Plan Option in which you were enrolled in 2018, rollover credits will be available January 1, 2019.

2018 Rollover Credits from Commercial (Non-MA) Plan Options to Medicare Advantage (MA) Plan Options: Any unused wellness credits will remain in your Health Reimbursement Arrangement (HRA), Health Incentive Account (HIA), MyIncentive Account (MIA) or Kaiser Permanente Rollover Account (KPRA) for a six-month run out period, to allow for prior year's claims processing.

If you have a balance of 100 credits or more in your HRA, HIA, MIA or KPRA after being enrolled in MA for at least six months and are not in a split option, an individual Retiree Reimbursement Account (RRA) will be set up by your Medicare Advantage Plan Administrator, Anthem or UnitedHealthcare.

The MA vendor will reimburse you for MA co-pay or co-insurance out-of-pocket expenses to the maximum balance in the RRA.

Telemedicine/Virtual Visits

Telemedicine/virtual visits is a benefit that is available to SHBP members under all Plan Options. Telemedicine allows healthcare professionals to evaluate, diagnose and treat patients using telecommunication technology. Through your plan's participating telemedicine/virtual visit providers, you will be able to see and/or talk to a participating provider from your mobile device, tablet or computer with a webcam while at home, work or on the go. Please see the Benefits Comparison Charts in this Decision Guide or contact the Medical Claims Administrators if you have questions.

Summary of Benefits and Coverage (SBC) for Commercial (Non-MA) Plan Options

SHBP provides Summary of Benefits and Coverage (SBC) for the following Commercial Plan Options: Health Maintenance Organization (HMO), Health Reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP). SBCs include standard information that help you to understand, evaluate and compare the Plan Options as you make decisions about which Plan Option to choose.

The SBCs are available online at www.shbp.georgia.gov and you may request a paper copy of the SBCs free of charge by calling SHBP Member Services at 800-610-1863.

ACTION ALERT

*If you or your enrolled dependent(s) experience a Qualifying Event (QE) during the Plan Year that results in coverage under a new identification (ID) number or a change in Plan Option and/or vendor, your well-being incentive will be forfeited. The deductible and out-of pocket maximum will not be transferred. For members enrolled in a Health Reimbursement Arrangement (HRA) Plan Option, if moving to a new HRA ID number and/or HRA Plan Option, the HRA base funding will be prorated based on the elected coverage tier and the months remaining in the current Plan Year. Deductibles, out-of-pocket maximums and any well-being incentive balances are not prorated nor transferrable. For additional information, please reference the Eligibility & Enrollment Provisions at **www.shbp.georgia.gov**.*

Annuitant Subsidy Policies

The State Health Benefit Plan (SHBP) has two subsidy policies that determine the amount of subsidy Annuitants (Retirees) will receive from the SHBP to cover the costs of their premiums. The amount of the subsidy a Retiree receives from SHBP lowers the monthly premium amount Retirees pay for their SHBP coverage.

Annuitant Basic Subsidy Policy (Old Policy)
Under the Annuitant Basic Subsidy Policy, the monthly premium amount a Retiree pays for SHBP coverage is the same across all Plan Options but the percentage varies as the costs of Plan Options vary.

You are subject to the Annuitant Basic Subsidy Policy if:

1. You were not an active employee on January 1, 2012, but were an Annuitant receiving a retirement check from a State retirement system – ERS or TRS and enrolled in SHBP retirement coverage on January 1, 2012; or

2. You were not an active State employee on January 1, 2012, but were a former State employee with eight years of service and enrolled in state extended SHBP coverage on January 1, 2012; or you were not an active Teacher or Public School employee on January 1, 2012, but were a former teacher or public school employee with eight years of service in a State retirement system but could not retire due to age and enrolled in state extended SHBP coverage on January 1, 2012; or

3. You were an active employee that on January 1, 2012 had five years of service in the State retirement system from where you will receive an annuity (ERS or TRS).

Annuitant Years of Service Subsidy Policy (New Policy)
Under the Annuitant Years of Service Subsidy Policy, the monthly premium amount a Retiree pays for SHBP coverage depends on the number of years of service reported to SHBP from the retirement system (ERS or TRS) in which the Retiree is eligible to receive an annuity.

You are subject to the Annuitant Years of Service Subsidy Policy if on January 1, 2012 you did not have five years of service in the State retirement system from where you will receive an annuity. The subsidy percentage for each member increases with every year of service beginning at 10 years through 30 or more years. Members with 0-9 years of service (i.e., less than 10 years of service) will receive no subsidy.

- For members, the subsidy range is a minimum of 15% for 10 years of service (i.e., 10 years of service = 15% subsidy), and a maximum of 75% for 30 or more years of service (i.e., 30 or more years of service = 75%; and cannot be greater than the subsidy for an Active Employee)

The subsidy amount for each dependent increases with every year of service for the member beginning at 10 years through 30 or more years.

- For dependents, the subsidy range is a minimum of 15% for a dependent if the member has 10 years of service, and a maximum of 55% if the member has 30 or more years of service (but cannot be greater than the subsidy for an Active Employee's dependent minus 20%)

Years of Service Reporting to SHBP
When a member retires, the applicable state retirement system (ERS or TRS) will provide SHBP information which indicates whether or not a member had five years of service as of January 1, 2012. For members subject to the new policy (i.e., did not have five years of service on January 1, 2012), each applicable state retirement system will also provide SHBP the number of years of service that a member had upon their retirement. Years of service are determined by the state retirement systems and not by SHBP.

Additional Information
SHBP rate calculators are available online at www. shbp.georgia.gov to assist Retirees with estimating their premiums during the 2019 Plan Year. For questions regarding the New Policy, please contact SHBP Member Services Center at 800-610-1863.

The Board of Community Health sets all member premiums by resolution and in accordance with the law and applicable revenue and expense projections. Any subsidy policy adopted by the Board may be changed at any time by Board resolution, and does not constitute a contract or promise of any amount of subsidy.

Retiree Option Change Period (ROCP) and Your Responsibilities

SHBP ENROLLMENT PORTAL FOR THE ROCP AVAILABLE FROM OCTOBER 15 AT 12:00 A.M. THROUGH NOVEMBER 2, 2018 AT 11:59 P.M. ET

Your Responsibilities as a State Health Benefit Plan (SHBP) Member

- Make your elections online at www.mySHBPga.adp.com no later than November 2, 2018 by 11:59 p.m. ET
- Read and make sure you understand the plan materials posted at www.shbp.georgia.gov and take the required actions
- Check your health insurance deduction to verify the correct deduction amount is made. If you are not being charged the correct amount, immediately contact SHBP Member Services
- Update any change in contact information (i.e., address, email, and phone number) by making the correction online at www.mySHBPga.adp.com during ROCP or call SHBP Member Services at 800-610-1863 for assistance
- Check with your applicable State retirement system to ensure SHBP premiums are being deducted from your retirement annuity, if applicable.
- Pay all required premiums by the due date if they are not automatically deducted from your retirement annuity
- Notify SHBP whenever you have a change in covered dependents within 31 days of a Qualifying Event (QE)
- Notify SHBP when you, a covered spouse, or dependent gain Medicare coverage within 31 days, including gaining coverage as a result of End Stage Renal Disease (ESRD)
- Within 3 - 6 months of you or your dependent(s) turning age 65, you and your covered dependent(s), as applicable, must enroll in Medicare Part B
- Provide your Medicare Part B information to SHBP for you and your covered dependent, if applicable, at least one month prior to you and your covered dependent, if applicable, turning age 65. If you are actively employed, you and your covered dependent age 65 or older, if applicable, must provide your Medicare Part B information to SHBP at least one month prior to your retirement.
- Continue to pay Medicare Part B premium to SSA if you are enrolled in a SHBP Medicare Advantage (MA) PPO Plan Option, and continue to pay your monthly SHBP coverage premiums to SHBP
- If you and/or your covered dependent(s) age 65 or older do not enroll in a SHBP MA PPO Plan Option, fail to provide the necessary information for SHBP to enroll you in a MA PPO Plan Option, or lose your eligibility to be enrolled in a SHBP MA PPO Plan Option, you will pay the unsubsidized cost of coverage, which is substantially higher
- Do not enroll in a third-party (non-SHBP) Medicare Advantage Plan, Medicare Part D Plan or Medicare Supplement, or you will lose eligibility for SHBP coverage.

During ROCP, you may:

- Change to any Plan Option and/or vendor for which you are eligible; however, you cannot add dependents to your coverage
- Drop covered dependents
- Discontinue SHBP coverage

IMPORTANT NOTE:

- **If you discontinue your SHBP coverage for any reason, you will not be able to re-enroll unless you return to work in a benefits eligible position that offers SHBP benefits**
- **If you return to work in a benefits eligible position after retiring, you will need to have health insurance premiums deducted from your paychecks as an active member (i.e., eligible employee of an SHBP Employing Entity). Upon retiring again, you must notify SHBP Member Services at 800-610-1863 within 31 days to request coverage as a retiree or you will no longer have coverage with SHBP**
- **When you retire, generally, your deductions will be taken from your retirement annuity check. If your retirement annuity check does not cover the cost of your premium, exceeds the maximum amount set yearly that SHBP will deduct from retirement annuities, or if an error occurs that prevents SHBP from receiving a premium deduction to cover your SHBP monthly premium, you will be placed on Direct Pay and should pay any bills that you receive from SHBP to continue your coverage as a retiree. For more information, call SHBP Member Services at 800-610-1863**
- **The election made during the 2018 ROCP will be the coverage you have for the entire 2019 Plan Year unless you have a QE that allows a change in your coverage**
- **Enrolling or discontinuing coverage from individual coverage offered through the Health Insurance Marketplace (exchange) is NOT a Qualifying Event (QE)**

Making Your Health Benefit Election for 2019

Retiree Option Change Period (ROCP) begins October 15, 2018, 12:00 a.m. ET and ends November 2, 2018, 11:59 p.m. ET

Before making your selection, we urge you to review the Plan Options described in this guide, discuss them with your family and choose a Plan Option that is best for you and your covered dependents, if applicable. **Due to expected heavy call volume and online traffic, we strongly encourage all members to confirm your access to the enrollment portal in advance of the Retiree Option Change Period (ROCP) election start date.**

Unable to Make Elections Online or Need Technical Assistance?

If you are unable to make your election(s) online or need technical assistance, please call SHBP Member Services at 800-610-1863 prior to the last day of ROCP.

How to Reset Your Password

Go to the Enrollment Portal: www.mySHBPga.adp.com

Step 1: Click **Forgot Your Password.**
Step 2: Enter Your User ID
Step 3: Follow the instructions to answer a series of security questions

Note: If you do not know the answers to the security questions, contact SHBP Member Services at 800-610-1863 to assist you with the password reset process. Again, due to expected heavy call volume and online traffic, we strongly encourage all members to confirm your access to the enrollment portal in advance of the Retiree Option Change Period (ROCP) election start date.

Step 4: Create a new Password
Step 5: Click **Continue**

If you answer the security questions wrong or spell the answer incorrectly (case sensitivity does not apply), you will have two more tries before you are locked out and must begin the process again.

What if I Do Not Take Any Action?

If SHBP does not receive an election from you through the website, or by contacting SHBP Member Services, you have made a decision to take the default coverage below:

- **Currently Enrolled in a SHBP Medicare Advantage Plan Option in 2018:** If you are enrolled in a Medicare Advantage with Prescription Drugs (MAPD) Preferred Provider Organization (PPO) Plan Option in 2018, you will remain in your current Medicare Advantage Plan Option and tier with your current Medical Claims Administrator for the 2019 Plan Year.
- **Currently Enrolled in a SHBP Commercial (non-Medicare Advantage) Plan Option in 2018:**
  If you are enrolled in a Commercial (non-Medicare Advantage Plan) Option in 2018, you will remain in your current Plan Option and tier with your current Medical Claims Administrator in 2019.
- Currently Enrolled in TRICARE Supplement in 2018:
  If you are enrolled in the TRICARE Supplement in 2018, you will remain enrolled in the TRICARE Supplement for 2019.

NOTE: If you paid a Tobacco Surcharge in 2018, it will continue to apply. If you did not pay a Tobacco Surcharge in 2018, you will not pay one if you default coverage. Remember, it is your responsibility to notify SHBP immediately if you and/or your covered dependent(s) no longer qualify for the Tobacco Surcharge. Also, it is your responsibility to contact SHBP if you and/or your covered dependent(s) resumes his/her tobacco use. You must notify SHBP if your answer to the Tobacco Surcharge question changes.

How to Make Your 2019 Health Benefit Election

Go to the SHBP Enrollment Portal: www.mySHBPga.adp.com

Step 1: Log on to the SHBP Enrollment Portal. If you are a first time user, you must first register using the registration code **SHBP-GA** and set up a password before making your 2019 election. If you are a returning user but have not accessed the website since 9/15/18 then you must first reset your password before making your 2019 election. The Home page displays a ROCP message indicating the event date for you on the top of the screen for elections to be in effect for the 2019 Plan Year.

NOTE: You will be able to elect a separate Dependent Health Benefit Option if you are in a Split Option. A Split Option is when you and your covered dependents are not eligible for the same plan option and must be enrolled in different plan options. For example, a member enrolled in a SHBP Medicare Advantage plan with a child under age 65 is able to choose a separate Commercial (non-MA) plan option for their child since they are not eligible to enroll in a SHBP Medicare Advantage plan. If you are not in a Split Option, you will not be able to make a Dependent Health Benefit election which means your covered dependents will be enrolled in the same plan option that you are enrolled in.

Step 2: Under the Open Enrollment window, **click on Continue** to proceed with your 2019 Plan Year enrollment.

Step 3: The Welcome page displays a Terms and Conditions message with the new Plan Year as the effective date. You must click **Accept Terms and Conditions** to continue to the next step of enrollment.

Step 4: **Click on Go to Review Your Current Elections.** This screen displays appropriate default enrollments for you.

Step 5: **Click on Go To Review Your Dependents (if applicable).** Verify that each dependent has a valid Social Security number (SSN) or other Taxpayer Identification Number (TIN).

NOTE: You can only add a dependent(s) if you have a Qualifying Event (QE).

Step 6: To start your Election Process, **click on Go to Make your Elections.**

Step 7: **Click on Go To Tobacco Surcharge question.** You MUST answer the tobacco surcharge question using the radio option

After you answer the Tobacco Surcharge question, the Decision Support box will display. You are provided an option to use the Decision Support Benefit Option Comparison Tool (i.e., Decision Support Tool) to help you choose the right plan to meet your needs. You can choose to decline or accept the opportunity to use the tool. Please see additional information on this page regarding the Decision Support Tools.

Step 8: **Click on Go to Health Benefits** to choose your Medical Claims Administrator(s), Plan Option(s) and coverage tier.

Step 9: **Make Your Elections.**

NOTE: For existing dependents, confirm that all dependents that require benefits have a check in the "Include in Coverage" box.

If you choose **NOT** to enroll in a Plan Option you must **click** the radio option for **No Coverage**. A pop-up box will then display **Reason for Waive**. You will need to select the drop-down box which will populate responses. Next, scroll through the options provided and select a reason. The **Reason for Waive** must be populated to move to the next step

Step 10: **Click on Go to Review and Confirm Changes** "Your Elections" will display on the screen and show the elections you made. You should carefully review your elections.

Step 11: **Click Finish.** If Finish is NOT clicked, your enrollment process has not been completed, which means you have decided to make no changes for 2019.

Take Advantage of Decision Support Tools to Help You Select the Health Care Option that Best Meets Your Personal and Financial Needs!

To help you with your enrollment choices, SHBP has included Decision Support Tools as part of the Enrollment Portal; using them, you will be provided with personalized, easy-to-understand information to assist you in making educated health care decisions. Decision Support Tools will help you choose the Plan Option that best meets your personal needs and circumstances.

NOTE: The Medicare Advantage Plan Options and TRICARE Supplement are not supported by Decision Support Tools.

RETIREE OPTION CHANGE PERIOD (ROCP) CHECKLIST

- ☑ Verify all desired dependents are listed on the Confirmation Page and have a valid Social Security Number (SSN) or other Taxpayer Identification Number (TIN)
- ☑ Verify your coverage tier (you only, you + spouse, you + child(ren) or you + family)
- ☑ Confirm that the Plan Option selected shown on the Confirmation Page is correct
- ☑ Confirm you have answered the Tobacco Surcharge question appropriately (applicable to Non-MA only)
- ☑ Confirm that you have clicked Finish
- ☑ Print Confirmation Page and save for your records

NOTE: You may go online multiple times; however, the last options confirmed at the close of ROCP will be your option for 2019, unless you experience a Qualifying Event (QE) that allows you to make a change.

Flexible Benefits Program

SHBP does not provide Flexible Benefits (e.g., dental, vision). If you are eligible to make benefit elections under the Flexible Benefits Program administered by the Department of Administration Services (DOAS), please visit www.GABreeze.ga.gov or call 877-342-7339.

Making Changes During the Plan Year When You Experience a Qualifying Event (QE)

Consider your benefit needs carefully and make the appropriate selection. The election made during the 2018 Retiree Option Change Period (ROCP) will be the coverage you have for the entire 2019 Plan Year, unless you have a Qualifying Event (QE) that allows a change in your coverage. You only have 31 days after a QE to add a dependent (90 days to add a newly eligible dependent child). For a complete description of QEs, see the Eligibility and Enrollment Provisions document available online at www.shbp.georgia.gov. You may also contact SHBP Member Services for assistance at 800-610-1863.

QEs include, but are not limited to:

- Birth, adoption of a child, or child due to legal guardianship
- Death of a currently enrolled spouse or enrolled child
- Your spouse's or eligible dependent's loss of eligibility for other group health coverage
- Marriage or divorce
- Medicare eligibility
- Loss of Medicaid eligibility (excluding voluntary discontinuation of coverage/ non-compliance/ failure to make payment)

Eligible Dependents*

State Health Benefit Plan (SHBP) covers eligible dependents who meet SHBP guidelines. Eligible dependents include:

- Spouse
- Dependent Child
  - Natural child
  - Adopted child
  - Stepchild
  - Child due to Guardianship

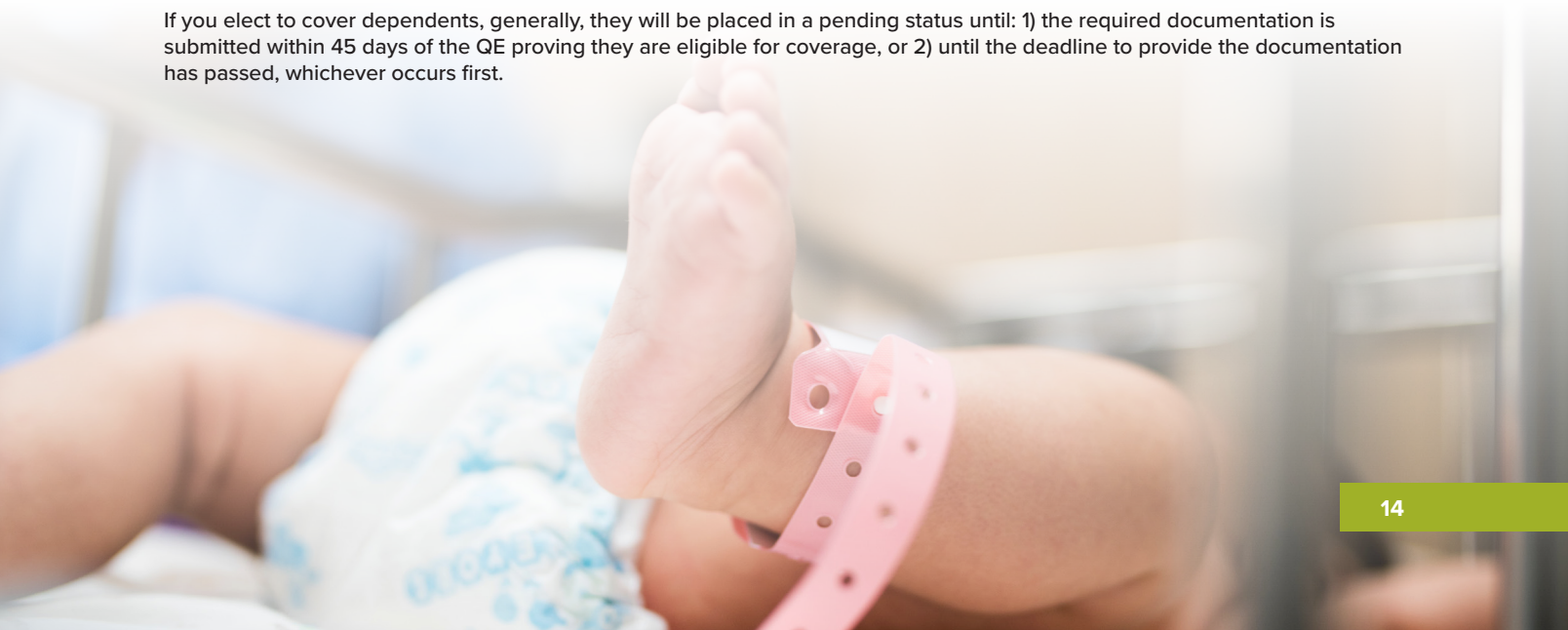
*Visit Eligibility and Enrollment Provisions document at www.shbp.georgia.gov for more information on continuation of coverage for covered dependents disabled prior to age 26.

How to Declare a Qualifying Event (QE)

To declare a Qualifying Event, you must log on to the SHBP Enrollment Portal at www.mySHBPga.adp.com or contact SHBP Member Services at 800-610-1863.

Note: You can declare a Qualifying Event (QE) in the SHBP Enrollment Portal on the day of, but no earlier than, the date on which the event actually occurs. For example, if your spouse loses his/her coverage with his/her current employer on November 29, 2018, you cannot declare the QE in the Enrollment Portal until November 29, 2018 (i.e., date of the event). If you do not declare the QE in the Enrollment Portal within 31 days of November 29, 2018 (i.e., date of the event), you will not be able to make your QE in the Enrollment Portal on a later date. When entering the QE in the portal, you must ensure that you enter the correct date of the event as this calculates the effective date of the change resulting from the QE. You may also call SHBP Member Services within the 31 days of the QE and the representatives will make the necessary changes for you.

If you elect to cover dependents, generally, they will be placed in a pending status until: 1) the required documentation is submitted within 45 days of the QE proving they are eligible for coverage, or 2) until the deadline to provide the documentation has passed, whichever occurs first.



2019 SHBP Medicare Advantage with Prescription Drugs (MAPD) Preferred Provider Organization (PPO) Plan Options

The 2019 SHBP Medicare Advantage (MA) Plan Options include:

- Anthem Blue Cross and Blue Shield MAPD PPO Standard
- Anthem Blue Cross and Blue Shield MAPD PPO Premium
- UnitedHealthcare MAPD PPO Standard
- UnitedHealthcare MAPD PPO Premium

SHBP's MA Plan Options are approved plans by the Centers for Medicare & Medicaid Services (CMS); they are sometimes called Part C Plans. These plans take the place of your original **Medicare Part A – Hospital, Medicare Part B – Medical and Medicare Part D – Prescription Drug benefit.** These plans are very similar to traditional PPO plans. You may receive benefits from in-network and out-of-network providers as long as the provider accepts and bills the MAPD Plans.

SHBP's MA PPO Plan Options also provide contracted networks on a statewide and national basis across the United States. You will have the choice of a MA PPO Standard or Premium plan under Anthem Blue Cross and Blue Shield or UnitedHealthcare. Additionally, you can see noncontracted providers as long as they accept and bill the MAPD Plans.

- You do not have to select a Primary Care Physician (PCP) or obtain a referral to see a Specialist (SPC)
- Co-pays apply toward the out-of-pocket maximum (except for Part D prescription drugs)
- Unlike traditional PPO plans, there is no difference in your co-pay/co-insurance levels if you see providers who are contracted (in-network) or providers who are not contracted (out-of-network). So, you are not penalized for going to a non-contracted provider that accepts Medicare and the MAPD Plans
- There will be no coverage if you see a provider who does not accept Medicare
- Enrollment in the MAPD PPO plans is subject to CMS approval and is prospective (retroactive enrollment is generally not allowed)
- **CMS requires a physical street address** and Medicare number before approving MAPD PPO coverage
- Once your enrollment is approved by CMS, CMS will notify the State Health Benefit Plan (SHBP) of the effective date of your coverage
- You must show your Anthem or UnitedHealthcare ID card, as applicable, in place of your Medicare card when receiving medical services and prescription drugs.

NOTE: When your covered dependent(s) is not eligible to participate in a SHBP MAPD option, you and your covered dependent(s) must enroll in a Split Option. A Split Option is where you and your covered dependents are not eligible for the same plan option and must be enrolled in different plan options.

IF YOU OR YOUR COVERED DEPENDENT ARE AGE 65 OR OLDER AND...	THEN...
You fail to provide your and/or your covered dependent's Part B information directly to SHBP one month prior to you and/or your covered dependent turning Age 65	You and/or your covered dependent(s) will remain enrolled in a SHBP Commercial (Non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.
You fail to provide your and/or your covered dependent's Part B information directly to SHBP one month prior to your retirement if currently working and covered as an active member	You and/or your covered dependent(s) will remain enrolled in a SHBP Commercial (Non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.
• You or your covered dependent(s) do not have a physical address on file, • You or your covered dependent(s) enroll in a third-party (non-SHBP) Medicare Advantage Plan, Medicare Part D Plan or Medicare Supplement, or • You or your covered dependent(s) lose Your Medicare Part B for any reason	Your and/or your covered dependent's Medicare Advantage with Prescription Drugs (MAPD) coverage under SHBP will be terminated and SHBP will move you to a Commercial (Non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.
You or your covered dependent(s) is without Medicare Part B	You and/or your covered dependent(s) will remain enrolled in or be enrolled in a SHBP Commercial (Non-MA) Plan Option (i.e., the Gold, Silver or Bronze HRA; one of the HMOs; or the HDHP) and you will pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options; -OR- You or your covered dependent's may purchase Part B to enroll in a MAPD option; however, you will be responsible for paying the Late Enrollment Penalty if you are enrolling late in Medicare after your Initial Enrollment Period prescribed by CMS for Medicare Parts A and/or B.

Enrollment in a SHBP Medicare Advantage Plan Option is prospective after any of the above circumstances, meaning until you are enrolled in a SHBP Medicare Advantage Plan Option you will remain enrolled in a SHBP Commercial (Non-MA) Plan Option and pay 100% of the unsubsidized premium, which is substantially higher than the SHBP Medicare Advantage Plan Options.

Benefits Comparison:
SHBP Medicare Advantage Standard And Premium Plan Options

Standard and Premium Plans
January 1, 2019 – December 31, 2019

	MAPD – Standard Anthem/UnitedHealthcare	MAPD – Premium Anthem/UnitedHealthcare
Covered Services	**You Pay**	**You Pay**
Deductibles	$0	$0
Out-of-Pocket Maximum Per Member[1]	$3,500 per member	$2,500 per member
Physicians' Services	**You Pay**	**You Pay**
Primary Care Physician or Specialist Office or Clinic Visits Treatment of illness or injury	PCP—$25 per office visit co-pay; SPC—$30 per office visit co-pay	PCP—$15 per office visit co-pay; SPC—$25 per office visit co-pay
Primary Care Physician or Specialist Office or Clinic Visits Annual Wellness Visit	$0 co-pay	$0 co-pay
Telemedicine/Virtual visit	$0 co-pay	$0 co-pay
Complex Radiology Services and Radiation Therapy Received in a Doctor's Office[2] (Doctor's office visit co-pay will apply)	$35 co-pay	$35 co-pay
Diagnostics Procedures and Testing Services Received in a Doctor's Office (Doctor's office visit co-pay will apply)	$0 co-pay	$0 co-pay
Annual Screenings Note: Pap smears are covered every 24 months unless high risk, then annually.	$0 co-pay; (mammograms, pap smears, prostate cancer screening, colorectal cancer screening)	$0 co-pay; (mammograms, pap smears, prostate cancer screening, colorectal cancer screening)
Hospital Services	**You Pay**	**You Pay**
Inpatient Hospital Services	20% co-insurance	20% co-insurance
Outpatient Hospital Services (includes observation, medical and surgical care)	$95 co-pay Observation Room $25 co-pay PCP $30 co-pay SPC	$50 co-pay Observation Room $15 co-pay PCP $25 co-pay SPC
Complex Radiology Service and Radiation Therapy Service[2] (When the service is performed at a hospital, outpatient facility or a free standing imaging or diagnostic center)	20% co-insurance	20% co-insurance
Diagnostic Procedures and Testing Services (When the service is performed at a hospital, outpatient facility or a free standing imaging or diagnostic center)[3]	$95 co-pay	$50 co-pay

[1] Not all covered services apply to out-of-pocket. Contact Anthem and UnitedHealthcare for details.
[2] The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specialty trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, sonograms, diagnostic mammograms and interventional radiological procedures (angiogram and barium studies).
[3] Other co-pays may apply.

Benefits Comparison:
SHBP Medicare Advantage Standard And Premium Plan Options

Standard and Premium Plans
January 1, 2019 – December 31, 2019
(continued)

	MAPD PPO – Standard Anthem/UnitedHealthcare	MAPD PPO – Premium Anthem/UnitedHealthcare
Behavioral Health	**You Pay**	**You Pay**
Mental Health and Substance Abuse Inpatient Facility	20% co-insurance per inpatient admission	20% co-insurance per inpatient admission
Mental Health and Substance Abuse Outpatient Visits	$30 co-pay Professional Individual & Group Therapy Visits $55 co-pay Professional Partial Hospitalization visits	$25 co-pay Professional Individual & Group Therapy Visits $50 co-pay Professional Partial Hospitalization visits
Dental	**You Pay**	**You Pay**
Dental and Oral Care Medicare covered	$25 per office visit co-pay for Medicare covered dental services	$15 per office visit co-pay for Medicare covered dental services
Vision	**You Pay**	**You Pay**
Routine Eye Exam NOTE: Limited to one eye exam every 12 months including refraction exam	$30 co-pay per office visit—limited to 1 annual eye exam; $125 eyewear benefit (glasses/frames or contact lenses) allowance every 24 months[1]	$25 co-pay per office visit—limited to 1 annual eye exam; $125 eyewear benefit (glasses/frames or contact lenses) allowance every 24 months[1]
Emergency Coverage	**You Pay**	**You Pay**
Ambulance Services NOTE: Land or air ambulance to nearest facility to treat the condition	$50 co-pay	$50 co-pay
Emergency Care	$50 co-pay; waived if admitted to hospital within 72 hours for the same condition	$50 co-pay; waived if admitted to hospital within 72 hours for the same condition
Urgent Care Services	$25 co-pay; waived if admitted to hospital within 72 hours for the same condition	$20 co-pay; waived if admitted to hospital within 72 hours for the same condition
Other Coverage	**You Pay**	**You Pay**
Home Health Care Services	$0 co-pay per visit	$0 co-pay per visit
Hearing Services and Hearing Aids Routine hearing exam	$0 co-pay limited to one exam every 12 months; $1,000 hearing aid allowance every 48 months	$0 co-pay limited to one exam every 12 months; $1,000 hearing aid allowance every 48 months
Skilled Nursing Facility Services Prior authorization required	$0 co-pay per day for days 1–20; $50 co-pay per day for days 21–100 for up to 100 days per benefit period (no prior hospital stay required)	$0 co-pay per day for days 1-20; $25 co-pay per day for days 21-100 for up to 100 days per benefit period (no prior hospital stay required)

[1] $0 co-pay for one pair of eyeglasses or contact lenses after cataract surgery.

Benefits Comparison:
SHBP Medicare Advantage Standard And Premium Plan Options

Standard and Premium Plans
January 1, 2019 – December 31, 2019
(continued)

	MAPD PPO – Standard Anthem/UnitedHealthcare	MAPD PPO – Premium Anthem/UnitedHealthcare
Other Coverage	**You Pay**	**You Pay**
Hospice Care	100% coverage; must receive care from a Medicare covered hospice facility; (no prior approval required). For services not related to the terminal condition member cost-shares may apply.	100% coverage; must receive care from a Medicare covered hospice facility; (no prior approval required). For services not related to the terminal condition member cost-shares may apply.
Durable Medical Equipment (DME) Prior approval required for certain DME.	20% coverage for Medicare covered items.	20% coverage for Medicare covered items.
Outpatient Acute Short-Term Rehabilitation Services • Physical Therapy • Speech Therapy • Occupational Therapy • Cardiac Therapy • Pulmonary Therapy	$25 co-pay per office visit for Medicare covered services	$10 co-pay per office visit for Medicare covered services
Chiropractic Care	Medicare covered: $18 co-pay per office visit; Routine Non-Medicare covered: $30 co-pay per office visit; limit of 20 visits per year.	Medicare covered: $18 co-pay per office visit; Routine Non-Medicare covered: $25 co-pay per office visit; limit of 20 visits per year.
Foot Care	Medicare covered: $30 co-pay per office visit; Routine Non-Medicare covered: $25 co-pay; limit of 6 visits per year.	Medicare covered: $25 co-pay per office visit; Routine Non-Medicare covered: $15 co-pay; limit of 6 visits per year
Pharmacy	**You Pay**	**You Pay**
Select Generic Co-pay	$0 retail or mail order	$0 retail or mail order
Tier 1 Co-pay	$15 retail—31-day supply; $37.50 mail order—90-day supply	$15 retail—31-day supply; $37.50 mail order—90-day supply
Tier 2 Co-pay	$45 retail—31-day supply; $112.50 mail order—90-day supply	$45 retail—31-day supply; $112.50 mail order—90-day supply
Tier 3 Co-pay	$85 retail—31-day supply; $212.50 mail order— 90-day supply	$85 retail—31-day supply; $212.50 mail order— 90-day supply
Tier 4 Co-pay	$85 retail—31-day supply; $212.50 mail order— 90-day supply	$85 retail—31-day supply; $212.50 mail order— 90-day supply

After your yearly true out-of-pocket (TROOP) cost reaches $5,100 for generic drugs, you will pay 5% co-insurance with a minimum co-pay of $3.40 and a maximum co-pay of $10.00, and for brand drugs you will pay 5% co-insurance with a minimum co-pay of $8.50 and a maximum co-pay of $40.00. Members enrolled in Anthem and UnitedHealthcare will continue to pay $0 for Select Generic Drugs listed in the formulary.

***NOTE:** While the co-pay amounts are not changing for 2019, you may want to check to see if the medications you are taking have changed tiers for 2019.*

2019 SHBP Commercial (Non-Medicare Advantage) Plan Options

SHBP Pre-Age 65 Members may elect a Commercial (Non-MA) Plan Option which includes the following:

Anthem Blue Cross and Blue Shield (Anthem)

- Health Reimbursement Arrangement (HRA) without co-pays
  - Gold
  - Silver
  - Bronze
- Statewide Health Maintenance Organization (HMO)

UnitedHealthcare

- High Deductible Health Plan (HDHP) with an option to open a HSA
- Statewide Health Maintenance Organization (HMO)

Kaiser Permanente (KP)

The KP Regional HMO (Metro Atlanta Service Area only) offers medical, wellness and pharmacy benefits. You must **live or work** in one of the below 27 counties within the Metro Atlanta Service Area to be eligible to enroll in KP:

Barrow	DeKalb	Lamar
Bartow	Douglas	Meriwether
Butts	Fayette	Newton
Carroll	Forsyth	Paulding
Cherokee	Fulton	Pickens
Clayton	Gwinnett	Pike
Cobb	Haralson	Rockdale
Coweta	Heard	Spalding
Dawson	Henry	Walton

SHBP members Age 65 or older who do not elect a SHBP MA Plan Option and/or are not eligible or have covered family members who are not eligible for a SHBP MA Plan Option can select a SHBP Commercial Non-MA Plan Option. However, you will pay the higher, unsubsidized cost of the coverage, which is substantially higher.

Additional Option

The TRICARE Supplement will continue to be available for those members enrolled in TRICARE. See “Alternative Coverage” section for additional information.

CVS Caremark

Administers the pharmacy benefits for members who enroll in Anthem and UnitedHealthcare Commercial (Non-MA) Plan Options. CVS Caremark will provide benefits for retail prescription drug products, mail order, home delivery and specialty pharmacy service.

NOTE: Members do not have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Use CVS Caremark’s pharmacy locator tool to find a network pharmacy near you.
https://info.caremark.com/shbp

Sharecare

Provides comprehensive well-being resources and incentive programs for members who enroll in Anthem and UnitedHealthcare Commercial (Non-MA) Plan Options. Sharecare will also administer the 2019 action based health incentives that will allow these SHBP members and their covered spouses to earn additional well-being incentives.

Understanding Your Plan Options For 2019

How the Health Reimbursement Arrangement (HRA) with Anthem Blue Cross and Blue Shield (Anthem) Works

The HRA is a Consumer-Driven Health Plan Option (CDHP) that includes a State Health Benefit Plan (SHBP) funded HRA account that provides first-dollar coverage for eligible medical and pharmacy expenses. The HRA Plan Options offer access to a statewide and national network of providers across the United States.

It is important to note that when you go to the doctor, you do not pay a co-pay. Instead, you pay the applicable deductible or co-insurance.

SHBP contributes HRA credits to your HRA account based on the HRA Plan Option and tier in which you are enrolled. If you have unused credits in your HRA account from 2018, those credits will roll over to the next Plan Year as long as you remain enrolled in a SHBP Plan Option, excluding TRICARE Supplement. If you were previously a member of another SHBP Plan Option, all unused 2018 well-being incentive credits will roll over to your 2019 HRA plan, or any other Plan Option, in April 2019.

NOTE: There is a date limitation to how the 2018 rollover credits can be used for reimbursement. Only eligible medical and pharmacy expenses incurred after the rollover in April 2019 will qualify for reimbursement using the 2018 rollover credits. Eligible medical and pharmacy expenses incurred between January and March 2019 are not eligible for reimbursement using 2018 rollover credits, unless you elect to remain in an HRA. If you stay in an HRA, rollover credits will be available January 1, 2019. However, until your unused 2018 credits roll over, your 2019 HRA credits funded by SHBP and any well-being incentive credits earned in 2019 (and available at the time claims are received), will be used to offset those eligible medical and pharmacy expenses incurred during this time period.

Plan Features:

- There are separate in-network and out-of-network deductibles and out-of-pocket maximums
- After you meet your annual deductible, you pay a percentage of the cost of your eligible medical and pharmacy expenses, called co-insurance
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care
- The credits in your HRA account are used to help meet your deductible and your out-of-pocket maximums
- There are no co-pays
- The medical and pharmacy out-of-pocket maximums are combined
- Pharmacy expenses are not subject to the deductible, instead, you pay co-insurance. If you have available HRA credits, these credits will be used to pay your co-insurance at the point of sale. Once the credits in your HRA account are exhausted, you are responsible for paying the co-insurance amount at the point of sale
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma and/or coronary artery disease
- If you enroll in the HRA Plan Option after the first of the year, your SHBP-funded base credits deposited into your HRA account will be prorated. However, your deductible and co-insurance will not be prorated
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as “preventive care” within the meaning of the Affordable Care Act (ACA)
- Telemedicine/virtual visits for certain medical and behavioral health services are available, in-network only

How the High Deductible Health Plan (HDHP) with UnitedHealthcare Works

The HDHP offers in-network and out-of-network benefits and provides access to one of the largest network of providers statewide and on a national basis across the United States. In addition to the HDHP's low monthly premium, an important benefit of the HDHP is you are able to open a Health Savings Account (HSA) that allows you to save money tax deferred to help offset your plan costs.

Members and their covered spouses enrolled in an UnitedHealthcare Plan Option can each earn a 240 well-being incentive credit match with a maximum combined up to 480 well-being incentive credits matched by UnitedHealthcare for completing wellness requirements under the plan.

The You coverage tier (single) deductible and out-of-pocket maximum will apply to each individual family member regardless of whether you cover more than one dependent or have family coverage. This means if your coverage tier is You + spouse, You + child(ren) or You + family, an individual family member only needs to meet the You coverage tier deductible and out-of-pocket maximum and his/her eligible medical and pharmacy expenses will be paid regardless of whether the family deductible has been satisfied. Furthermore, once the You coverage tier (single) out-of-pocket maximum has been satisfied for that individual family member, all eligible medical and pharmacy expenses will be paid at 100% for the Plan Year for that family member.

For example:
An individual that is covered under a family coverage tier, regardless of how many family members are in that tier, will have a maximum individual in-network deductible of $3,500 and a maximum individual in-network out-of-pocket of $6,450. The individual out-of-network deductible maximum will not exceed $7,000 and the individual out-of-network out-of-pocket maximum will not exceed $12,900. Additionally, an individual family member may not contribute more than their own individual deductible or out-of-pocket maximum to the overall family deductible and out-of-pocket maximum.

Plan Features:

- There are separate in-network and out-of-network deductibles and out-of-pocket maximums
- You pay co-insurance after meeting the deductible for all eligible medical and pharmacy expenses until the out-of-pocket maximum is met
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care
- There are no co-pays
- The medical and pharmacy out-of-pocket maximums are combined
- Before you can use well-being incentive credits, members must meet the deductible threshold ($1,350 individual; $2,700 other tiers)
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management (DM) Programs for diabetes, asthma, and/or coronary artery disease. Members must satisfy the deductible threshold ($1,350 individual; $2,700 other tiers)
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA)
- Telemedicine/virtual visits for certain medical services are available, in-network only

How the High Deductible Health Plan (HDHP) with UnitedHealthcare Works (continued)

Health Savings Account (HSA)

An HSA is like a personal savings account with investment options for health care, except it's all tax-free. You may open an HSA with Optum Bank (a subsidiary of UnitedHealthcare), an independent bank, or an independent HSA administrator/custodian.

NOTE: HSA accounts cannot be combined with a Flexible Spending Account (FSA).*

You can open an HSA if you enroll in the State Health Benefit Plan (SHBP) High Deductible Health Plan (HDHP) and do not have other coverage through:

1) Your spouse's employer's plan,
2) Medicare, or
3) Medicaid

HSA Features:

- Must be enrolled in an HDHP
- The HSA cannot be used with a FSA*
- Only the amount of the actual account balance is available for reimbursement
- The employee owns the account and keeps the account
- Balances rollover each plan year
- Investment options are available with a minimum balance and interest accrues on a tax-free basis
- Contributions can start, stop or change anytime
- Distributions cover qualified medical expenses as defined under Section 213(d) of the Internal Revenue Code and certain other expenses
- Tax form 1099 SA and 5498 are sent to employees for filing

**May be used with a general, limited purpose FSA. For more details, please contact your FSA administrator.*

How the Statewide Health Maintenance Organization (HMO) with Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Works

An HMO allows you to receive covered medical services from in-network providers only (except for emergency care). You are not required to select a Primary Care Physician (PCP) with the Statewide HMO. Verify your provider is in-network before selecting an HMO Plan Option. When using in-network providers, request that they use or refer you to other in-network providers. The HMO offers a statewide and national network of providers across the United States.

Members and their covered spouses enrolled in an UnitedHealthcare Plan Option can each earn a 240 well-being incentive credit match with a maximum combined up to 480 well-being incentive credits matched by UnitedHealthcare for completing wellness requirements under the plan.

Plan Features:

- There are co-pays with this plan for certain services
- Certain services are subject to a deductible and co-insurance (see the Benefits Comparison Chart)
- You do not have to obtain a referral to see a Specialist (SPC); however, we encourage you to select a PCP to help coordinate your care
- Coverage is only available when using in-network providers (except for emergency care)
- The Plan pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA)
- Co-pays count toward your out-of-pocket maximum
- Co-pays do not count toward your deductible
- The medical and pharmacy out-of-pocket maximums are combined
- Certain drug costs are waived if SHBP is primary and you actively participate in one of the Disease Management Programs (DM) for diabetes, asthma, and/or coronary artery disease
- Telemedicine/virtual visits are available, in-network only

How the Regional Health Maintenance Organization (HMO) with Kaiser Permanente (KP) Works

The KP Regional HMO option is available to State Health Benefit Plan (SHBP) members who **live or work** in one of the 27 counties within the Metro Atlanta Service Area listed below.

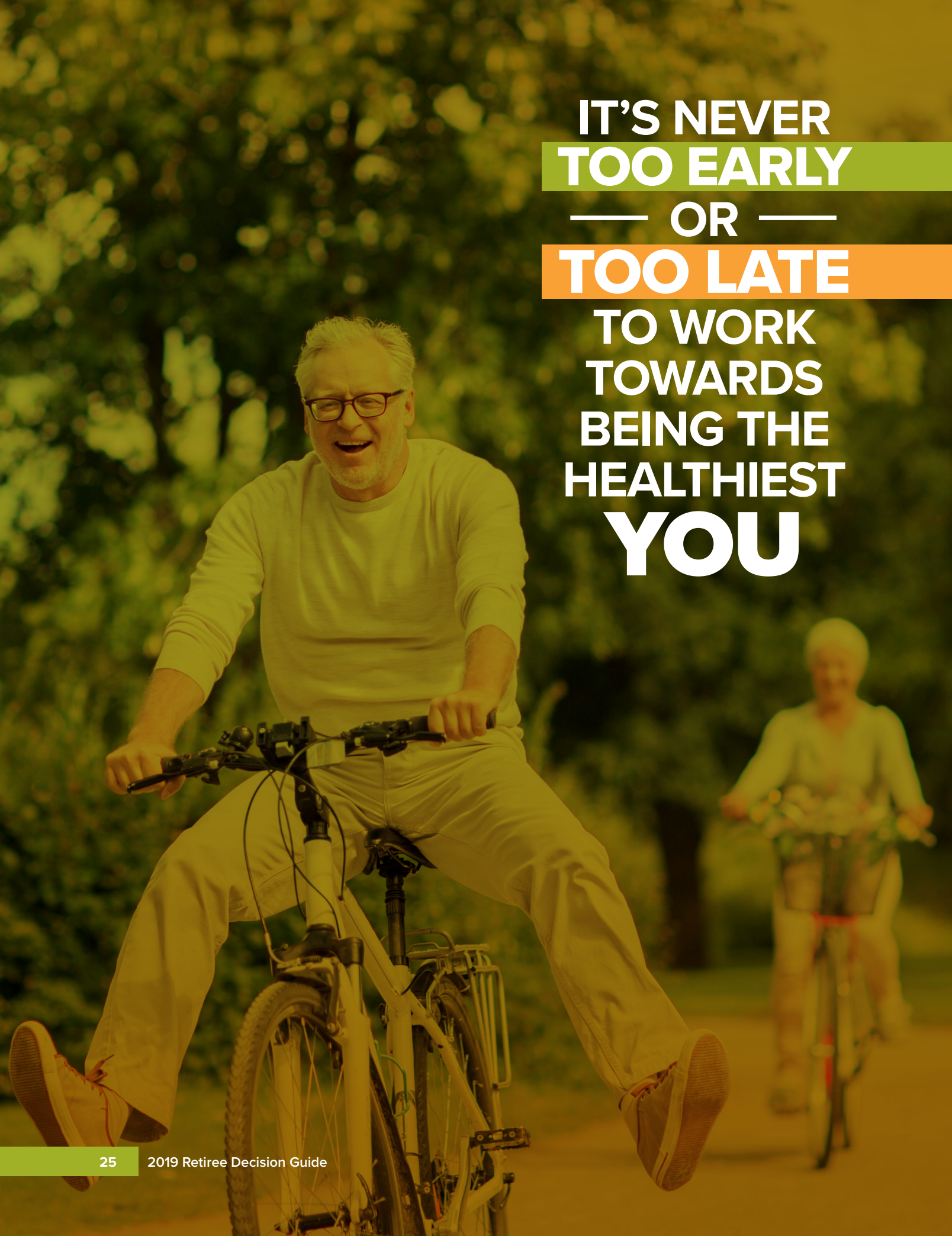
Barrow	DeKalb	Lamar
Bartow	Douglas	Meriwether
Butts	Fayette	Newton
Carroll	Forsyth	Paulding
Cherokee	Fulton	Pickens
Clayton	Gwinnett	Pike
Cobb	Haralson	Rockdale
Coweta	Heard	Spalding
Dawson	Henry	Walton

You are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers. You can schedule an appointment without a referral with any specialist at a KP medical facility. To select a PCP, you can log onto www.my.kp.org/shbp or call KP's Member Services at 855-512-5997.

The KP Regional HMO option pays 100% of covered services provided by in-network providers that are properly coded as "preventive care" within the meaning of the Affordable Care Act (ACA). KP administers the benefits for medical, pharmacy and wellness.

Plan Features:

- This is a co-pay only option
- There are no deductibles or co-insurance
- The medical and pharmacy out-of-pocket maximums are combined
- Telemedicine/virtual visits are available without co-pays
- You and your covered spouse can each earn a $500 Mastercard reward card for the completion of specific KP wellness activities


IT'S NEVER
TOO EARLY
— OR —
TOO LATE
TO WORK
TOWARDS
BEING THE
HEALTHIEST
YOU

Benefits Comparison:

SHBP Commercial (Non-Medicare Advantage) Plan Options

Please read the Benefits Comparison tables in this guide carefully and look at your medical and prescription expenses to make sure you understand the out-of-pocket costs under each option. In addition, you can find premium rates included with your enrollment information or online at www.shbp.georgia.gov.

Benefits Comparison:

HRA Plans

January 1, 2019 - December 31, 2019

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem Bronze HRA Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Covered Services	**You Pay**		**You Pay**		**You Pay**	
Deductible • You • You + Spouse • You + Child(ren) • You + Family	$1,500 $2,250 $2,250 $3,000	$3,000 $4,500 $4,500 $6,000	$2,000 $3,000 $3,000 $4,000	$4,000 $6,000 $6,000 $8,000	$2,500 $3,750 $3,750 $5,000	$5,000 $7,500 $7,500 $10,000
	HRA credits will reduce 'You Pay' amounts					
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	$4,000 $6,000 $6,000 $8,000	$8,000 $12,000 $12,000 $16,000	$5,000 $7,500 $7,500 $10,000	$10,000 $15,000 $15,000 $20,000	$6,000 $9,000 $9,000 $12,000	$12,000 $18,000 $18,000 $24,000
	HRA credits will reduce 'You Pay' amounts					
HRA	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
• You • You + Spouse • You + Child(ren) • You + Family	$400 $600 $600 $800		$200 $300 $300 $400		$100 $150 $150 $200	
Physicians' Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Primary Care Physician or Specialist Office or Clinic Visits • Treatment of illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Maternity Care (Non-routine, prenatal, delivery, and postpartum)	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/ preventive health care • Prenatal care coded as preventive	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered	100% coverage; not subject to deductible	Not covered
Physician Services Furnished in a Hospital • Inpatient Visits; including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Telemedicine/Virtual visit	85% coverage; not subject to deductible	Not covered	80% coverage; not subject to deductible	Not covered	75% coverage; not subject to deductible	Not covered

Benefits Comparison:
HMO and HDHP Plans

January 1, 2019 - December 31, 2019

	Anthem / UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Covered Services	**You Pay**	**You Pay**		**You Pay**
Deductible • You • You + Spouse • You + Child(ren) • You + Family	 $1,300 $1,950 $1,950 $2,600	 $3,500 $7,000 $7,000 $7,000	 $7,000 $14,000 $14,000 $14,000	 $0 $0 $0 $0
Out-of-Pocket Maximum • You • You + Spouse • You + Child(ren) • You + Family	 $4,000 $6,500 $6,500 $9,000	 $6,450 $12,900 $12,900 $12,900	 $12,900 $25,800 $25,800 $25,800	 $6,350 $12,700 $12,700 $12,700
HRA	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
• You • You + Spouse • You + Child(ren) • You + Family	N/A	N/A		N/A
Physicians' Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Primary Care Physician or Specialist Office or Clinic Visits • Treatment of illness or injury	100% coverage after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $35 PCP co-pay $45 SPC co-pay
Maternity Care (Non-routine, prenatal, delivery, and postpartum)	100% coverage after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $35 PCP co-pay $45 SPC co-pay
Primary Care Physician or Specialist Office or Clinic Visits for the following: • Wellness care/preventive health care • Prenatal care coded as preventive	100% coverage; not subject to deductible, in-network only	100% coverage; not subject to deductible	Not covered	100% coverage
Physician Services Furnished in a Hospital • Inpatient Visits; including charges by surgeon, anesthesiologist, pathologist and radiologist	100% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Telemedicine/Virtual visit	100% coverage after $35 PCP co-pay	70% coverage; subject to deductible	Not covered	100% coverage

Benefits Comparison:

HRA Plans

January 1, 2019 - December 31, 2019

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem Bronze HRA Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Physicians' Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Physician Services for Emergency Care	85% coverage; subject to deductible		80% coverage; subject to deductible		75% coverage; subject to deductible	
Allergy Shots and Serum	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • When billed as an office visit	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • When billed as an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Services	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Inpatient Services • Well newborn care	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Outpatient Surgery/Services • At a hospital or other facility	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	85% coverage; subject to in-network deductible		80% coverage; subject to in-network deductible		75% coverage; subject to in-network deductible	
Outpatient Testing, Lab, etc.	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits--for the treatment of an illness or injury	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible

Benefits Comparison:

HMO and HDHP Plans

January 1, 2019 - December 31, 2019

	Anthem /UnitedHealthcare Statetewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Physicians' Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Physician Services for Emergency Care	100% coverage	70% coverage; subject to in-network deductible		100% coverage
Allergy Shots and Serum • Co-pay only applies when billed with an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an office visit	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay
Outpatient Surgery/Services • When billed as an outpatient surgery at a facility; including charges by surgeon, anesthesiologist, pathologist and radiologist	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Services	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $250 co-pay
Inpatient Services • Well newborn care	100% coverage; not subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Outpatient Surgery/Services • At a hospital or other facility	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage after $100 co-pay
Hospital Emergency Room Care • Treatment of an emergency medical condition or injury	100% coverage after $150 co-pay, if admitted co-pay waived	70% coverage; subject to in-network deductible		100% coverage after $150 co-pay, if admitted co-pay waived
Outpatient Testing, Lab, etc.	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Non-Routine Laboratory; X-Rays; Diagnostic Tests; Injections • Including medications covered under medical benefits--for the treatment of an illness or injury	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage at KP or contracted facility $100 co-pay at outpatient hospital facility
Complex Radiology Testing MRIs, CTs, PET and Nuclear Medicine	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	$45 co-pay at KP or contracted free-standing imaging center $100 co-pay at outpatient hospital facility

Benefits Comparison:

HRA Plans

January 1, 2019 - December 31, 2019

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem Bronze HRA Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Behavioral Health	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Mental Health and Substance Use Disorder (MH/SUD) Inpatient Facility and Residential Treatment Centers. **NOTE:** Prior approval required.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
MH/SUD: Outpatient Visits--Professional and Methadone Clinics	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Outpatient Acute Short-Term Rehab Services • Physical, Speech and Occupational Therapies • Other Short-Term Rehab Services **NOTE:** There is a benefit maximum of 40 visits (combined in-network and out-of-network) per therapy in a benefit year.	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Chiropractic Care Coverage up to a maximum of 20 visits per Plan Year	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Vision Routine Eye Exam **Note:** Limited to one eye exam every 24 months	100% coverage; not subject to deductible Out-of-network Eye exam not covered		100% coverage; not subject to deductible Out-of-network Eye exam not covered		100% coverage; not subject to deductible Out-of-network Eye exam not covered	
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	Not covered	100% coverage	Not covered	100% coverage	Not covered
Hearing Services Non-routine hearing not performed in an office setting	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Hearing Aid -- Adults Fittings	85% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; not subject to deductible		80% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; not subject to deductible		75% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; not subject to deductible	
Hearing Aid -- Children (Up to age 19) Fittings	85% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible		80% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible		75% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible	

Benefits Comparison

HMO and HDHP Plans

January 1, 2019 - December 31, 2019

	Anthem/UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Behavioral Health	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Mental Health and Substance Use Disorder (MH/SUD) Inpatient Facility and Residential Treatment Centers.* **NOTE:** Prior approval required.	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $250 co-pay *Contact KP directly for benefit coverage.
MH/SUD: Group Outpatient Visits, Intensive Outpatient, Partial Day Hospitalization, and Methadone Clinics*	100% after $35 PCP per visit. 100% after $45 SPC per visit. $10 co-pay for group therapy	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 SPC per visit. $17 co-pay for group therapy *Contact KP directly for benefit coverage.
MH/SUD: Outpatient Visits--Professional and Methadone Clinics*	100% after $35 PCP co-pay $45 SPC co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 PCP co-pay $45 SPC co-pay *Contact KP directly for benefit coverage.
Other Coverage	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Outpatient Acute Short-Term Rehab Services • Physical, Speech and Occupational Therapies • Other Short-Term Rehab Services **NOTE:** There is a benefit maximum of 40 visits (combined in-network and out-of-network) per therapy in a benefit year.	100% after $25 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $25 co-pay
Chiropractic Care Coverage up to a maximum of 20 visits per Plan Year	100% after $45 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $45 co-pay
Vision Routine Eye Exam **Note:** Limited to one eye exam every 24 months	100% coverage; not subject to deductible, in-network only	100% coverage; not subject to deductible Out-of-network Eye exam not covered		100% coverage; not subject to deductible in-network only
Hearing Services Routine Hearing Exam when properly coded as preventive	100% coverage	100% coverage; not subject to deductible	Not covered	100% coverage
Hearing Services Non-routine hearing not performed in an office setting	80% coverage; subject to deductible	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $100 co-pay in outpatient setting or $250 co-pay in inpatient setting
Hearing Aid -- Adults Fittings	100% for exam and fittings; after $35 PCP co-pay $45 SPC co-pay $1,500 hearing aid allowance every five years; not subject to deductible	70% coverage for exam and fittings; subject to deductible $1,500 hearing aid allowance every five years; subject to deductible		100% coverage for exam and fittings $1,500 hearing aid allowance every five years
Hearing Aid -- Children (Up to age 19) Fittings	100% for exam and fittings; after $35 PCP co-pay $45 SPC co-pay $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to the deductible	70% coverage for exam and fittings; subject to deductible $3,000 hearing aid allowance per hearing impaired ear every four years; subject to the deductible		100% coverage for exam and fittings $3,000 hearing aid allowance per hearing impaired ear every four years; not subject to deductible

Benefits Comparison:

HRA Plans

January 1, 2019 - December 31, 2019

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem Bronze HRA Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Coverage	**The Plan Pays**		**The Plan Pays**		**The Plan Pays**	
Applied Behavior Analysis **NOTE:** Requires prior approval, only covered for treatment for autism spectrum disorders	85% coverage not subject to deductible $35,000 benefit maximum per Plan Year		80% coverage not subject to deductible $35,000 benefit maximum per Plan Year		75% coverage not subject to deductible $35,000 benefit maximum per Plan Year	
Urgent Care Services	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Home Health Care Services **NOTE:** Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Skilled Nursing Facility Services **NOTE:** Prior approval required	85% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered	80% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered	75% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered
Hospice Care **NOTE:** Prior approval required	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Durable Medical Equipment (DME) - Rental or purchase **NOTE:** Prior approval required for certain DME	85% coverage; subject to deductible	60% coverage; subject to deductible	80% coverage; subject to deductible	60% coverage; subject to deductible	75% coverage; subject to deductible	60% coverage; subject to deductible
Transplant Services **NOTE:** Prior approval required	Contact the Medical Claim Administrator for coverage details					

The Plan may pay a percent of the Maximum Allowable Amount for Covered Services performed by out-of-network providers; the Maximum Allowable Amount is usually 110% of the Medicare rate for the treatment. Deductibles and out-of-pocket maximums are based only on these eligible expenses and do not include amounts you pay when out-of-network providers balance bill for the difference. You cannot use HRA credits to pay for amounts balance billed.

NOTE: For out-of-network providers, the Plan does not accept assignment of benefits. You will receive a payment of benefits, and it will be your responsibility to pay that to the provider.

Benefits Comparison:
HMO and HDHP Plans

January 1, 2019 - December 31, 2019

	Anthem/UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Other Coverage	**The Plan Pays**	**The Plan Pays**		**The Plan Pays**
Applied Behavior Analysis **NOTE:** Requires prior approval, only covered for treatment for autism spectrum disorders	100% after $35 PCP co-pay $45 SPC co-pay $35,000 benefit maximum per Plan Year	70% coverage; subject to deductible $35,000 benefit maximum per Plan Year		100% after $35 PCP co-pay $45 SPC co-pay $35,000 benefit maximum per Plan Year
Urgent Care Services	100% after $35 co-pay	70% coverage; subject to deductible	50% coverage; subject to deductible	100% after $35 co-pay
Home Health Care Services **NOTE:** Prior approval required	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Skilled Nursing Facility Services **NOTE:** Prior approval required	100% in-network coverage; up to 120 days per Plan Year	70% coverage; up to 120 days per Plan Year; subject to deductible	Not Covered	100% in-network coverage; up to 120 days per Plan Year
Hospice Care **NOTE:** Prior approval required	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Durable Medical Equipment (DME) - Rental or purchase **NOTE:** Prior approval required for certain DME	100% coverage	70% coverage; subject to deductible	50% coverage; subject to deductible	100% coverage
Transplant Services **NOTE:** Prior approval required	Contact the Medical Claim Administrator for coverage details			

The plan may pay a percent of the Maximum Allowable Amount for Covered Services performed by out-of-network providers; the Maximum Allowable Amount is usually 110% of the Medicare rate for the treatment. Deductibles and out-of-pocket maximums are based only on these eligible expenses and do not include amounts you pay when out-of-network providers balance bill for the difference. You cannot use incentive credits to pay for amounts balance billed.

NOTE: For out-of-network providers, the Plan does not accept assignment of benefits. You will receive a payment of benefits, and it will be your responsibility to pay that to the provider.

Benefits Comparison:
HRA Pharmacy

January 1, 2019 - December 31, 2019

	Anthem Gold HRA Option		Anthem Silver HRA Option		Anthem Bronze HRA Option	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Other Coverage	**You Pay**		**You Pay**		**You Pay**	
Tier 1 Co-insurance **NOTE:** per 31-day maximum supply.	15% ($20 min/$50 max); not subject to deductible		15% ($20 min/$50 max); not subject to deductible		15% ($20 min/$50 max); not subject to deductible	
Tier 2 Co-insurance Preferred Brand **NOTE:** per 31-day maximum supply.	25% ($50 min/$80 max); not subject to deductible		25% ($50 min/$80 max); not subject to deductible		25% ($50 min/$80 max); not subject to deductible	
Tier 3 Co-insurance Non-Preferred Brand **NOTE:** per 31-day maximum supply.	25% ($80 min/$125 max); not subject to deductible		25% ($80 min/$125 max); not subject to deductible		25% ($80 min/$125 max); not subject to deductible	
Participating 90-day Voluntary Mail Order OR Retail 90-day Network	Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max)		Tier 1–15% ($50 min/$125 max) Tier 2–25% ($125 min/$200 max) Tier 3–25% ($200 min/$312.50 max)	

**NOTE:* *For HRA Out-of-Network, please refer to the Health Reimbursement Arrangement (HRA) plan option Summary Plan Description (SPD).*

NOTE: *Amounts you pay go toward the out-of-pocket maximum.*

NOTE: *If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Generic Co-pay in addition to the difference between the Brand and Generic Drug costs. This differential will not apply towards your out-of-pocket maximum.*

NOTE: *CVS Caremark administers the pharmacy benefits for members enrolled in Anthem HRA Plan Options.*

Benefits Comparison:

HMO and HDHP Pharmacy

January 1, 2019 - December 31, 2019

	Anthem/UnitedHealthcare Statewide HMO Option	UnitedHealthcare HDHP Option		KP Regional HMO Option
	In-Network Only	In-Network	Out-of-Network*	In-Network Only
Other Coverage	**You Pay**	**The Plan Pays**		**You Pay**
Tier 1 Co-insurance **NOTE:** per 31-day maximum supply. KP per 30-day max.	$20 co-pay	70% coverage; after deductible is met		$20 co-pay
Tier 2 Co-insurance Preferred Brand **NOTE:** per 31-day maximum supply. KP per 30-day max.	$50 co-pay	70% coverage; after deductible is met		$50 co-pay
Tier 3 Co-insurance Non-Preferred Brand **NOTE:** per 31-day maximum supply. KP per 30-day max.	$90 co-pay	70% coverage; after deductible is met		$80 co-pay
Participating 90-day Voluntary Mail Order OR Retail 90-day Network	Tier 1–$50 Tier 2–$125 Tier 3–$225 co-pays	70% coverage; after deductible is met		Tier 1–$50 Tier 2–$125 Tier 3–$225 co-pays

NOTE: *Co-pay amounts you pay do not go toward the deductible; however, they do go toward the out-of-pocket maximum.*

****NOTE:*** *For HDHP Out-of-Network, please refer to the High Deductible Health Plan (HDHP) plan option Summary Plan Description (SPD).*

NOTE: *If you request a Brand-name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (Generic equivalent), you will pay the applicable Generic co-pay/co-insurance in addition to the difference between the Brand and Generic Drug costs. This differential will not apply towards your out-of-pocket maximum.*

NOTE: *CVS Caremark administers the pharmacy benefits for members enrolled in Anthem HMO and UnitedHealthcare HMO and HDHP Plan Options. Kaiser Permanente administers the pharmacy benefits for members enrolled in their Plan Option.*

Alternative Coverage

TRICARE Supplement for Eligible Military Members

Are you career retired military or a reservist? Consider the TRICARE Supplement Plan

The TRICARE Supplement Plan is an alternative to State Health Benefit Plan (SHBP) coverage that is offered to members and dependents who are eligible for SHBP coverage and enrolled in TRICARE. The TRICARE Supplement Plan is not sponsored by the SHBP, the Georgia Department of Community Health (DCH) or any employer. The TRICARE Supplement Plan is sponsored by the Government Employees Association, Inc. (GEA) and is administered by Selman & Company. In general, to be eligible, the members and dependents must each be under age 65, ineligible for Medicare and registered in the Defense Enrollment Eligibility Reporting System (DEERS).

Who is eligible for enrollment in the TRICARE Supplement Plan?

Members who are eligible for enrollment in the TRICARE Supplement Plan include the following:

- Retired military receiving retired, retainer or equivalent pay.
- Retired Reservists between the ages of 60 and 65.
- Retired Reservists under age 60 and enrolled in TRICARE Retired Reserve (TRR).
- Qualified National Guard and Reserve Members enrolled in TRICARE Reserve Select (TRS)
- Spouses/surviving spouses of any of the above

Points to consider if you elect TRICARE Supplement Plan coverage

- Effective January 1, 2019, TRICARE will become your primary coverage
- TRICARE Supplement Plan will become the secondary coverage
- The eligibility rules and benefits described in the TRICARE Supplement Plan will apply:
  - Unmarried adult children under the age of 26 who are no longer eligible for regular TRICARE must be enrolled in TRICARE Young Adult (TYA) through TRICARE before enrolling in the TRICARE Supplement Plan
  - Unmarried children under the age of 21 or 23 if a full-time student who are no longer eligible for regular TRICARE, must be enrolled in TYA through TRICARE before enrolling in the TRICARE Supplement Plan
- Tobacco Surcharge will not apply

For complete information about eligibility and benefits, contact 866-637-9911 or visit **www.selmantricareresource.com/ga_shbp**. You may also find information at **www.shbp.georgia.gov**.

2019 Wellness

Wellness for Members Enrolled in Anthem Blue Cross and Blue Shield (Anthem) and UnitedHealthcare Commercial (Non-Medicare Advantage) Plan Options

The State Health Benefit Plan (SHBP) is excited to continue working with our Wellness partner, Sharecare. If you elect Anthem or UnitedHealthcare coverage, you and your covered spouse have access to SHBP's well-being program (administered by Sharecare) called Be Well SHBP. This program offers comprehensive well-being resources and incentives to support your goals for health and well-being. If you want to take big steps toward improved well-being or just a small step in the right direction, Sharecare can help. The program is confidential, voluntary and offered at no additional cost to you.

The Sharecare team will provide you with the support, tools, and lifestyle management information you need to improve your health and well-being. The types of support you receive includes: the Sharecare RealAge Test that determines your body's true age; a highly personalized profile; personalized content to help improve your health habits, earn green days with daily tracking; wellness resources, access to a personal well-being coach; a biometric screening; activities and presentations at your workplace; resources for quitting tobacco; fitness, weight, steps and nutrition challenges; access to recipes, meal plans, trackers, articles and more. To learn more about the many features of the current program, visit the program site at www.BeWellSHBP.com.

2019 Well-Being Incentives for Anthem and UnitedHealthcare Commercial (Non-Medicare Advantage) Plan Options*

Members and their Covered Spouses can each earn 480 well-being Incentive Points and choose to redeem them in the Sharecare Redemption Center for either: 1) a $150 Visa Reward Card (when redeeming all 480 well-being incentive points earned in 2019) OR 2) 480 well-being incentive credits (to apply toward eligible medical or pharmacy expenses)***OR 3) A $225 Walmart Gift Card (when redeeming all 480 well-being incentive points in 2019) to be used in Walmart stores for pharmacy prescriptions and vision items (restrictions apply).**

For details or questions, go to www.BeWellSHBP.com or call 888-616-6411

If You Complete...	You Will Earn...
The RealAge Test Take a confidential, online questionnaire that will take about 10 minutes to complete. It is recommended that you complete the RealAge test early in 2019 to allow for completion of action items below.	**120 well-being incentive points****
A Biometric Screening You have two options to complete your Biometric Screening: through your physician or at an SHBP-sponsored screening event.	**120 well-being incentive points****
The Coaching Pathway, Online pathway, or a Combination of Both	**Up to 240 well-being incentive points in the following increments****:**
Telephonic Coaching Pathway Actively engage in telephonic coaching with a Sharecare wellness coach.	**Telephonic Coaching Pathway** • Earn 60 well-being incentive points for each completed coaching call per calendar month, up to 4 times. • Maximum of one call in a calendar month qualifies you for the 60 well-being incentive points. • Maximum of 240 well-being incentive points.
Online Pathway or Challenges Complete either: • Green Days within the challenge period, which include daily trackers such as steps, sleep, stress, blood pressure, weight, and smoking; or • Complete the monthly 5K Steps Challenge per day Log 8 Green Day trackers or 5K Steps per day monthly within the Sharecare app or on the online platform.	**Online Pathway or Challenges** Earn 120 well-being incentive points up to 2 times, for a maximum of 240 well-being incentive points by completing two of the following challenges: • Complete 60 of 90 Green Days Challenge (3 separate periods will be offered from January 1, 2019 – November 30, 2019) • Complete 5K Steps Challenge per day (Monthly steps challenges will be offered from January 1, 2019 – November 30, 2019)

*All actions must be completed and appropriate documentation (including the Biometric Screening through your physician by completing the Physician Screening Form or at an SHBP-sponsored screening event) submitted and received by Sharecare between January 1, 2019 and November 30, 2019. It is your responsibility to ensure your information is complete and all documentation is received by Sharecare by November 30, 2019.

**Well-being Incentive Points are saved in the Sharecare Redemption Center until you choose to redeem them, meaning well-being incentive points will not be sent automatically to Anthem or UnitedHealthcare. Therefore, Members must make their selection on how they choose to redeem their points through the Redemption Center, by visiting www.BeWellSHBP.com.

***If you elect to redeem all 480 well-being incentive points earned in 2019 for the $150 Visa Reward Card, it can be used anywhere Visa is accepted and will be physically mailed within 8 weeks of redemption. If you elect to redeem all 480 well-being incentive points earned in 2019 for the $225 Walmart Gift Card, it can be used in Walmart stores for pharmacy prescriptions and vision items (restrictions apply) and will be physically mailed within 8 weeks of redemption. If you elect to redeem your points for well-being incentive credits to apply toward eligible medical and pharmacy expenses, you may do so in increments of 120 (up to a maximum of 480). Credits will be available within 30 days of redemption and will be deposited into your HRA, MIA, or HIA account. You **will not** be able to select the Visa Gift Card **OR** Walmart Gift Card options if you begin redeeming well-being incentive points for incentive credits.

****Note:** Well-being incentive points cannot be awarded until completion of the RealAge test. Biometrics, Telephonic Coaching and Online Pathways taken before completion of the RealAge test can only be applied to well-being incentive points upon RealAge test completion.

To learn more about how well-being incentives work with your Plan Option, please see the chart on the next page: "How Your Well-being Incentive Credits Work with Your Plan Option"

How Your Well-being Incentive Credits Work with Your Plan Option

For well-being incentive points earned through Sharecare, after you choose to redeem your points with the Sharecare Redemption Center for well-being incentive credits to apply toward eligible medical and pharmacy expenses (which you may do so in increments of 120 up to a maximum of 480), credits will be available within 30 days of redemption and will be deposited into your MIA, HRA, or HIA account. *See 2019 Well-Being Incentives for Anthem and UnitedHealthcare Commercial (Non-Medicare Advantage) Plan Options Chart for details.*

Plan Option	Account Type	When You Must Redeem Your Points for Credits	How Your Credits Work
Anthem HMO	MyIncentive Account (MIA)	All well-being incentive points earned in 2019 must be redeemed through Sharecare's Redemption Center (well-being incentive points will not be sent automatically to your health plan).	When you use your benefits, you pay the member responsibility, including provider/pharmacy co-pay, co-insurance or deductible as you normally would. Once the claim has been paid, information is sent to the MIA program. If you have MIA credits to cover all, or a portion of the member responsibility that you've paid, Anthem will mail you a reimbursement check (up to the amount of MIA credits available) along with a MIA summary.
Anthem HRA	Health Reimbursement Account (HRA)	Members enrolled in a HRA plan option receive account based credits funded by SHBP, which are available immediately and do not require redemption in the Sharecare Redemption Center. All well-being incentive points earned in 2019 must be redeemed through Sharecare's Redemption Center (well-being incentive points will not be sent automatically to your health plan).	When you use your benefits, any funds that are owed to providers/pharmacies will be automatically paid by Anthem out of your HRA first. You will not pay anything until all of your available HRA credits have been used.
UnitedHealthcare HMO	Health Incentive Account (HIA)	Members enrolled in the UnitedHealthcare HMO receive a credit match funded by UnitedHealthcare. All well-being incentive points earned in 2019 must be redeemed through Sharecare's Redemption Center (well-being incentive points will not be sent automatically to your health plan).	When you use your benefits, you pay the provider/pharmacy co-pay, co-insurance or deductible upfront. If you have HIA credits to cover all, or a portion of the expense, UnitedHealthcare will automatically send you a reimbursement check (up to the amount of HIA credits available).
UnitedHealthcare HDHP	Health Incentive Account (HIA)	Members enrolled in the UnitedHealthcare HDHP receive a credit match funded by UnitedHealthcare. All well-being incentive points earned in 2019 must be redeemed through Sharecare's Redemption Center (well-being incentive points will not be sent automatically to your health plan).	You first pay a portion* of your deductible to activate your ability to use your HIA credits. Once that portion of your deductible has been met, when you use your benefits, any funds owed to providers will be automatically paid by UnitedHealthcare out of your HIA (up to the amount of HIA credits available). For pharmacy, you will pay upfront. If you have enough credits in your HIA to cover all, or a portion of the expense, UnitedHealthcare will automatically mail you a reimbursement check (up to the amount of HIA credits available). *Portion of Your Deductible: You: $1,350 You + Child(ren): $2,700 You + Spouse: $2,700 You + Family: $2,700 The above amounts reflect a portion of the total required Deductible.

Note: If you terminate your coverage with SHBP, any unused MIA, HRA, or HIA credits will be forfeited.

Wellness for Members Enrolled in Kaiser Permanente Regional HMO Plan Option

State Health Benefit Plan (SHBP) is excited to continue to partner with Kaiser Permanente (KP). They offer a comprehensive and integrated team approach to wellness. In addition, KP provides a variety of wellness tools and resources and an incentive program designed to empower you to take an active role in your own health. You will have access to KP's tools, activities and services such as: the Total Health Assessment, biometric screenings, and online and onsite healthy living classes. To learn more about KP services and programs, visit **www.my.kp.org/shbp**.

Kaiser Permanente Rollover Account (KPRA)

The KPRA will be available to members enrolling with KP who were previously enrolled in another SHBP Plan Option during 2018 that have unused incentive credits earned in SHBP's Be Well SHBP program administered by Sharecare. The balance will roll over in April 2019. With the KPRA, members will be able to use those unused credits for eligible medical and pharmacy expenses incurred after April 2019, while insured under the KP Regional HMO plan. If you have questions regarding your KPRA, contact KPRA customer service after April 2019 at 877-761-3399 or visit **www.kp.org/healthpayment**.

You must first pay your medical co-pay(s) out-of-pocket. Normally, within 15 days of when the claim is processed, you will be reimbursed your co-pay(s) from the available funds in your KPRA. Your KPRA comes with a KP Prescription Drug Card. To maximize your pharmacy benefits, you should use this card at KP pharmacies to pay your co-pay(s) at the point of sale. Although the KP prescription card is accepted outside of the KP network, you will have to pay the full cost of the drug as this is not a covered benefit under your Plan.

2019 Wellness Incentives for Kaiser Permanente

Earn up to $1,000 and feel the benefits of taking care of your health!

Simply sign-up for the KP Wellness Program at my.kp.org/shbp and make sure you are up-to-date on all four of the activities listed below. Each member and their covered spouse who satisfies the KP Wellness Program requirements will receive a $500 Mastercard reward card ($1,000 per household)! Use your wellness incentive to further embrace your Total Health.

Getting your reward is easy and there is no specific order in which these four wellness activities must be completed! Just sign on to my.kp.org/shbp to accept your Wellness Program agreement, which is required for reward eligibility. For details or questions go to my.kp.org/shbp or call 866-300-9867.

NOTE: All actions must be completed between January 1, 2019 and November 30, 2019.

	What to Do	What You will Earn
1.	**Take Your Total Health Assessment:** Complete your KP on-line Total Health Assessment (THA). The questionnaire is confidential and only takes about 20 minutes.	***How will YOU use your $500 Wellness Incentive reward? Complete all four activities and earn a Mastercard reward card worth $500.*** • Pay for co-pays and prescription medications for the entire year • Relieve stress with quarterly massages • Take a nice weekend hiking trip in the mountains • Splurge on new work-out clothes or walking shoes • Stock up on healthy foods at the grocery store ***Both members and their covered spouses are eligible to earn the incentive for a total of $1000 per household.***
2.	**Know Your Numbers** Complete a Biometric Screening at a Kaiser Permanente Medical Office, or by a KP clinician at an SHBP-sponsored biometric screening event. **NOTE:** ONLY those screenings performed by KP are eligible for the reward.	
3.	**Get Yourself Screened:** Complete all age and gender appropriate preventive screenings for breast, cervical or colorectal cancer.	
4.	**Take an Online Course:** Complete one online Healthy Lifestyle Program (HLP)	

Note: If you terminate your coverage with SHBP, any unused KPRA credits will be forfeited.

Tobacco Policies

Tobacco Cessation
Every attempt to quit tobacco is worth the effort. It takes planning, support and sometimes, all the will power you've got. But quitting for good is absolutely possible. Both Sharecare and KP offer comprehensive online and telephonic tobacco cessation services that provide the tools and support you need to quit successfully. Both programs are confidential, voluntary and are at no additional cost to you. To learn more, Members enrolled in Anthem and UnitedHealthcare should visit www.BeWellSHBP.com and Members enrolled in KP should visit www.my.kp.org/shbp.

Tobacco Cessation Medications
Prescription and over-the-counter (OTC) tobacco cessation therapies, including nicotine replacement therapy (NRT), are available. For Members enrolled in Anthem and UnitedHealthcare, please go to http://info.caremark.com/shbp to learn more. For Members enrolled in KP, please go to www.my.kp.org/shbp to learn more.

Tobacco Surcharge
Tobacco surcharges are included in all SHBP Plan Options (except for the Medicare Advantage Plan Options and TRICARE Supplement). These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Online and Telephonic Coaching Programs. Please go to: www.shbp.georgia.gov to access the tobacco surcharge removal policies. These policies allow you to have the tobacco surcharge removed by completing the Tobacco Surcharge Removal Requirements.

Tobacco Surcharge Removal/Refund
In compliance with the Affordable Care Act (ACA) requirements for wellness programs, SHBP's covered tobacco users (members and covered dependents) may qualify for tobacco surcharge refunds or adjustments of premiums paid in 2019 by completing the Tobacco Surcharge Removal Requirements in the Tobacco Users Cessation Policies for Anthem, UnitedHealthcare and KP at: www.shbp.georgia.gov.

Legal Notices

About the Following Notices

The following important legal notices are also posted on the State Health Benefit Plan (SHBP) website at www.shbp.georgia.gov under Plan Documents:

Penalties for Misrepresentation

If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when enrolling in benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP for fraud for indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

To avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician/Provider (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network, and who is available to accept you or your family members. For children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCP's, call the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on the back of your Identification Card.

HIPAA Special Enrollment Notice

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:

- The Covered Person's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call SHBP Member Services at 1-800-610-1863 or visit the SHBP Enrollment Portal: www.mySHBPga.adp.com.

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other medical and surgical benefits under your Plan Option. Following cancer surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification.

For more detailed information on the mastectomy-related benefits available under your Plan option, call the telephone number on the back of your Identification Card.

For more detailed information on the mastectomyrelated benefits available under your Plan option, call the telephone number on the back of your Identification Card.

Newborns' and Mothers' Health Protection Act of 1996

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES

Georgia Department of Community Health State Health Benefit Plan Notice of Information Privacy Practices

Revised June 28, 2018

The purpose of this notice is to describe how medical information about you, which includes your personal information, may be used and disclosed and how you can get access to this information. Please review it carefully.

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy. DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" (PHI), and includes any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. This notice tells how your PHI is used and shared by DCH and Plan Representatives. DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Only Summary Information is Used When Developing and/or Modifying the Plan. The Board of Community Health, which is the governing Board of DCH, the Commissioner of DCH and the Chief of the Plan administer the Plan and make certain decisions about the Plan. During those processes, they may review certain reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any individual person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DCH may provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information may only be used by your employer to obtain health insurance quotes from other sources and make decisions about whether to continue to offer the Plan. Please note that DCH, Plan Representatives, and your employer are prohibited by law from using any PHI that includes genetic information for underwriting purposes.

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information, "Enrollment Information" and "Claims Information". "Enrollment Information" includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment.

"Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

Your PHI is Protected by HIPAA. Under HIPAA, employees of DCH and employees of outside companies and other vendors hired or contracted either directly or indirectly by DCH to administer the Plan are "Plan Representatives," and therefore must protect your PHI. These Plan Representatives may only use PHI and share it as allowed by HIPAA, and pursuant to their "Business Associate" agreements with DCH to ensure compliance with HIPAA and DCH requirements.

DCH Must Ensure the Plan Complies with HIPAA. DCH must make sure the Plan complies with all applicable laws, including HIPAA. DCH and/or the Plan must provide this notice, follow its terms and update it as needed. Under HIPAA, Plan Representatives may only use and share PHI as allowed by law. If there is a breach of your PHI, DCH must notify you of the breach.

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI.

HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing.

Claims Administrator Companies: Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers.

Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan; and communicate with the Plan Members and/or their health care providers.

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan.

State of Georgia Attorney General's Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan.

Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI.

Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.

NOTE: Treatment is not provided by the Plan but we may use or disclose PHI in arranging or approving treatment with providers.

Under HIPAA, all employees of DCH must protect PHI and all employees must receive and comply with DCH HIPAA privacy training. Only those DCH employees designated by DCH as Plan Representatives for the SHBP health care component are allowed to use and share your PHI.

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations. HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following:

Compliance with a Law or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law or to prevent a serious threat to health and safety.

Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities.

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies, as applicable, that may provide you or your dependents benefits (such as state retirement systems or other state or federal programs) in order to get information about your or your dependent's eligibility for the Plan, to improve administration of the Plan, or to facilitate your receipt of other benefits.

Research Purposes: Your PHI may be given to researchers for a research project, when the research has been approved by an institutional review board. The institutional review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you and/or with your legal personal representative. However, the Plan may provide limited information to the employee about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. Plan Representatives may not use or share your PHI for any reason that is not described in this notice without a written authorization by you or your legal representative. For example, use of your PHI for marketing purposes or uses or disclosures that would constitute a sale of PHI are illegal without this written authorization. If you give a written authorization, you may revoke it later.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to Inspect and Obtain a Copy of your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or incomplete, you may contact the Plan to request a correction.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures.

Right to Ask for a Restriction of Uses and Disclosures or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety.

Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Member Services Center at 1-800-610-1863 or you may download a copy at www.shbp.georgia.gov. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Addresses to File HIPAA Complaints:

Georgia Department of Community Health
SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

U.S. Department of Health & Human Services
Office for Civil Rights Region IV
Atlanta Federal Center
61 Forsyth Street SW Suite 3B70
Atlanta, GA 30303-8909
1-877-696-6775

For more information about this Notice, contact
Georgia Department of Community Health
State Health Benefit Plan
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

CMS Medicare Part D Creditable Coverage Notice

Centers for Medicare and Medicaid Services (CMS) Medicare Part D Creditable Coverage Notice

Important Notice from the Department of Community Health about Your 2019 Prescription Drug Coverage under the State Health Benefit Plan and Medicare for Plan Year: January 1 – December 31, 2019

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug coverage with the State Health Benefit Plan (SHBP) and about your options under Medicare's Prescription Drug coverage.

This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Department of Community Health has determined that the Prescription Drug coverage offered under SHBP is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is, therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable Prescription Drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Part D Drug Plan?

If you decide to join a Medicare drug plan, your current SHBP coverage will be affected. If you join a Medicare drug plan and do not terminate your SHBP coverage, SHBP will coordinate Benefits with the Medicare drug plan coverage the month following receipt of the notice. You should send a copy of your notice to SHBP at: P.O. Box 1990, Atlanta, GA 30301-1990.

IMPORTANT: If you are a retiree and terminate your SHBP coverage, you will not be able to get this SHBP coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SHBP and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, if you don't join within 63 continuous days after your current coverage ends, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the SHBP Member Services Center at:
1-800-610-1863.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SHBP changes. You also may request a copy of this notice at any time.

CMS Medicare Part D Creditable Coverage Notice (continued)

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare Prescription Drug coverage:

- Visit: www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE at: 1-800-633-4227 (TTY 1-877-486-2048)

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov or call at: 1-800-772-1213 (TTY: 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

From: January 1, 2019 **To:** December 31, 2019
Date: June 28, 2018

Summaries of Benefits and Coverage

Summaries of benefits and coverage describe each Plan Option in the standard format required by the Affordable Care Act. These documents are posted here: www.shbp.georgia.gov/plan-documents-policies-forms. To request a paper copy, you may call the SHBP Member Services Center 1-800-610-1863.

Georgia Law Section 33-30-13 Notice:

SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 0% higher than it would be if the Affordable Care Act provisions did not apply.

Website for the Annual Retiree Option Change Period Available October 15 at 12:00 a.m. through November 2 at 11:59 p.m. ET

For Plan Coverage effective January 1, 2019 – December 31, 2019

The material in this booklet is for informational purposes only and is not a contract. It is intended only to highlight principal benefits of the State Health Benefit Plan (SHBP) Plan Options. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan Documents, the Plan Documents govern. For all Plan Options other than the Medicare Advantage (MA) option, the Plan Documents including the SHBP regulations, are the Summary Plan Descriptions, Evidence of Coverage documents and reimbursement guidelines of the vendors. The Plan Documents for MA are the Evidence of Coverage (EOC) and the Rx Certificate of Coverage. It is the responsibility of each member, active and retired, to read the plan documents to fully understand how that option pays benefits. Availability of SHBP options may change based on federal or state law changes or as approved by the Board of Community Health.

Premiums for SHBP Plan Options are established by the DCH Board and may be changed at any time by Board Resolutions subject to advance notice.

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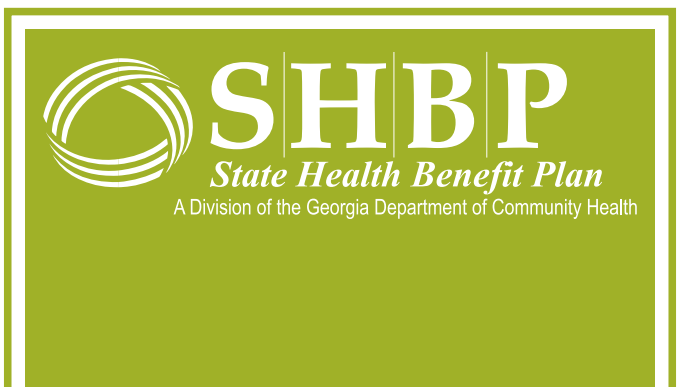
SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health